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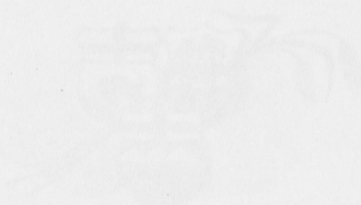


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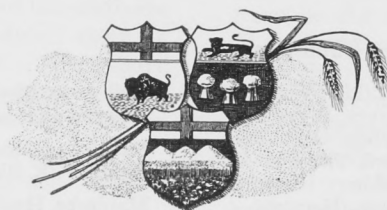
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SURGERY

Vagotomy in Duodenal Ulcer

A Review of 98 Cases*

K. R. Trueman, M.D.

Division of Surgery

J. W. Macleod, M.D.; D. L. Kippen, M.D.

Division of Medicine

Gastric resection and vagotomy with posterior gastro-enterostomy are the two operative procedures employed in the surgical treatment of chronic duodenal ulcer which has failed to respond to medical therapy.

Vagotomy alone or combined with some other procedure has been employed as one of the methods in the surgical management of duodenal ulcer at the Winnipeg Clinic since May, 1946. This report concerns the 98 cases subjected to vagotomy from May, 1946, to May, 1949, as reviewed from one to four years later.

Material

The series comprises 98 cases of chronic duodenal ulcer. The average duration of symptoms exceeded twelve years. Haemorrhage occurred on one or more occasions in eighteen of the patients, and perforation in ten. Jejunal ulcer was present in seven cases. Criteria for surgical interference were those generally accepted, the majority of cases being studied pre-operatively by members of the Medical and Surgical departments.

Follow-up information was derived primarily from questionnaires, with personal interviews in 75% and post-operative radiological examinations in 52% of cases. Insulin secretion studies have not been done routinely. The limitations of this test as a measure of complete vagotomy have been well set forth by Weinstein and Hollander¹.

As elsewhere, transthoracic vagotomy was eventually replaced by sub-diaphragmatic vagotomy combined with posterior gastro-enterostomy² or gastric resection. The distribution of cases is shown in Table 1. The questionnaire sought information concerning the relief, modification or persistence of the original ulcer pain; vomiting of blood or passage of tarry stools; dyspepsia or the use of antacid; gain, maintenance or loss of weight; ability to resume original occupation, and the general reaction to the operation, good or bad. This was completed by 87 of the 98 cases. Of the remainder three are known to have died and eight have not been traced.

*Presented at the Annual Meeting of the Manitoba Medical Association, October 4th, 1950.

Results

In this report the results of treatment are classified as Good, Fair, and Poor according to the criteria proposed by Ross³.

A Good result implies freedom from any gastrointestinal symptoms; absence of any suggestion of ulcer recurrence; return to normal weight, and ability to resume the previous occupation.

A Fair result implies freedom from ulcer distress or any suggestion of ulcer recurrence, but permits the presence of slight gastro-intestinal symptoms; or slight to moderate side effects of the operation, such as bloating or diarrhoea. There must be the ability to enjoy an average diet and to resume the original occupation.

A Poor result implies evidence suggestive of ulcer recurrence, such as typical pain, haemorrhage, or the presence of a crater by x-ray; or severe side effects, such as persistent vomiting or diarrhoea; marked restriction of diet or regular use of antacids; inability to regain weight and strength or to resume the previous occupation.

It was sometimes difficult to allocate a case to its proper category, especially in the Fair group. Actually, most of those classed as Fair in this report are quite satisfactory from the standpoint of ulcer control, and the patient was satisfied with the operation. An analysis of the results according to the operative procedure is set forth in table 2.

Table 1

Types of Operation in Vagotomy Series

Chronic Duodenal Ulcer	Number of Cases
Vagotomy	36*
Vagotomy and posterior gastro-enterostomy	35
Vagotomy and subtotal gastric resection ..	20
Jejunal Ulcer (following gastro-enterostomy alone)	
Vagotomy	6
Vagotomy and Subtotal Gastric Resection	1
Total	98

*Three subsequently underwent gastro-enterostomy.

Discussion

A—Simple Vagotomy:

In our early operations, simple vagotomy was employed, usually by the transthoracic route. The immediate post-operative freedom from ulcer pain in most cases was in accordance with the general experience. Nevertheless, only 20 of the 31 fol-

lowed cases (64%) were assessed as yielding Good results three or four years later.

It was soon learned that gastric retention was a common accompaniment of the operation. This was due, it is believed, to the influence of two factors, viz., the greatly decreased motor power of the stomach following successful vagotomy, and the presence of a degree of stenosis resulting from fibrosis about the healing ulcer. The presence of slight stenosis in chronic ulcer was overlooked in the beginning of our work, and no doubt accounts for distressing and continuing retention in some of these cases.

In this regard, although retention of gastric secretion and food has caused vomiting or considerable distress in some, others, with roentgenological evidence of 50-70 per cent retention five hours after a barium meal have had no complaints. Diarrhoea which has been reported as a very common accompaniment of vagotomy occurred to some degree in 11 (30%) of our simple vagotomies in the first few weeks following surgery. Our present information reveals that only two cases continue to have significant bouts of diarrhoea.

Table 2

Operation:	Number of Cases	Good	Fair	Poor	No Follow-up	Deaths
Vagotomy	36 ¹	20	2	9	3	1 ²
Vagotomy and Gastro-enterostomy	38 ¹	26	9	2	1	0
Vagotomy and gastric resection	20	8	5	3	2	2
Vagotomy for jejunal ulcer ..	6	4	1	—	1	0
Vagotomy and gastric resection for jejunal ulcer ..	1	—	—	1	0	—

¹ Three cases had simple vagotomy but later required gastro-enterostomy. One of these cases is too recent for review purposes and not included.

² Death in this case followed post-operative dismissal as noted below.

A consideration of the two cases in the group with Fair results reveals one to have moderate post-prandial bloating and occasional vomiting. He has had no ulcer symptoms, and a barium meal six months following surgery demonstrated no crater and only 10% retention at five hours.

The other case occasionally uses alkalis for vague distress when his stomach is empty. A barium meal nearly three years after vagotomy does not show an ulcer.

The Poor cases in this group included one death. This patient had persistent ulcer symptoms with death eighteen months later. The clinical picture was said to suggest perforation of a peptic ulcer. This patient's insulin secretion test post-operatively indicated an incomplete resection of the vagus nerves.

The remaining 9 cases graded as Poor included five with recurrence of ulcer pain. Two of these and have had hematemesis and melena and three have exhibited ulcer craters by barium meal. Four other patients were regarded as failures because of the distress attending marked obstruction. Three of these four subsequently underwent gastroenterostomy, the two which are followed up being included in the cases of the next section.

B—Vagotomy and Gastroenterostomy

The problem of gastric retention following vagotomy has been largely overcome by the simultaneous provision of a gastroenterostomy. Even then care must be taken in the immediate post-operative period to keep the stomach decompressed. If the gastric residue is checked at bedtime before additions in diet are made little trouble is experienced. Some do continue to have a degree of retention as seen at the 5-hour inspections of the barium meal, but this seldom is accompanied by symptoms. In fact, the appearance of some evidence of hypotonicity following the operation is a welcome sign since it indicates complete nerve section to be more likely.

Twenty-six (72%) of this group are classed as Good, being relieved of all gastro-intestinal symptoms and experiencing no vagotomy side effects. They are enthusiastic over this kind of ulcer treatment.

The nine cases (24%) classed as Fair were satisfactory from the standpoint of the main problems of ulcer control and maintenance of weight. However, eight of them have varying degrees of discomfort following meals, three of these tending to vomit after a very full meal. The ninth case has had troublesome bouts of diarrhoea since the operation.

Of the Poor results (5%), one patient experienced an ulcer type of distress on two occasions in three and a half years—each episode coinciding with an influenza-like illness. The other case is one which has had gastroenterostomy following earlier vagotomy treatment. He is constantly bloated, vomits after meals and states he has observed tarry stools once since his second operation. Unfortunately, there has been no opportunity to interview this patient.

There were no operative deaths among the thirty-eight patients who had both vagotomy and gastroenterostomy.

C—Vagotomy and Gastric Resection

This double procedure was performed in twenty-six cases, on two of which there are no follow-up data. The decision of the surgeons to carry out a subtotal gastrectomy on these occasions was probably based on various considerations, viz., need of drainage, unusually high acidity, fear of recurrence, ease of resection, etc. Even in these cases post-operative retention was sometimes troublesome.

This was a heterogeneous group to begin with and the results up to the present have been disappointing. Only eight (44%) of the eighteen cases followed are classed as Good results.

The five cases in the Fair group give no suggestion of ulcer recurrence. However, they all experience bloating, nausea and the occasional vomiting of bile stained material. Two complain of frequent bouts of diarrhoea. One of these has a verified steatorrhoea with most of the features of the sprue syndrome. This case will be reported fully in another communication. One patient has lost thirty pounds in weight and another fifteen. Weak spells and easy fatigue occur in two. Nevertheless, these cases were classed as Fair rather than Poor because of the gratifying relief of severe ulcer pain and the absence on re-examination of any evidence of recurrence of the ulcer tendency.

In addition to two patients who died, three cases are classed as Poor results. They all experience unusual bloating and frequent vomiting after meals. Anorexia is present and weight loss has been excessive, one of them losing twenty-six and another thirty pounds. Two of them gave negative x-ray examinations. The third, who has suffered severe pain, relieved by antacid, and has had hematemesis and melena, has not been available for investigation. Almost certainly he has recurrent ulceration. There were two post-operative deaths. Post mortem examination revealed massive pulmonary atelectasis in one case, and a large collection of free blood in the abdomen of the other.

In considering the results of this double operation of vagotomy and gastric resection one would like to distinguish between the complications attributable to loss of vagus innervation and those due to loss of gastric capacity and pyloric control. At present this distinction cannot be made fully. It is likely that the vagotomy was incomplete in several cases at least. Moreover, all of these symptoms are encountered occasionally after gastrectomy without vagotomy. A follow-up of the ulcer cases treated by gastrectomy alone is projected. Its results may cast light on this problem.

D—Vagotomy for Jejunal Ulcer

Our experience with vagus section for this complication of previous gastric surgery for duodenal ulcer is limited in the series to seven cases. On six there is follow-up information. Five of these were treated by vagotomy alone and the sixth case which has had previous partial gastrectomy underwent further resection in addition to vagotomy. Of the five simple vagotomies, four of which were done by thoracotomy, all but one are well in every respect. The fifth case also claimed freedom from symptoms when interviewed in December, 1949, almost three years after his operation. Radiologically there was

no suggestion of abnormality at the stoma. In his reply to the questionnaire several months later, however, this patient stated that he had "gnawing pain at times" for which he took no medication. Pending further information this was rated as a Fair rather than Good result.

The single instance of gastric resection along with vagotomy for jejunal ulcer is graded as a Poor result but merits special qualifications. He had suffered many ulcer complications and had undergone several operations elsewhere, including gastroenterostomy and gastric resection. At operation a large stoma ulcer was found amid a mass of adhesions. By a high resection plus vagotomy it was hoped he would be relieved of his ulcer tendency, and it is believed that this has been achieved. Over a two-year period he has been interviewed frequently and twice examined radiologically. There is no suggestion of ulcer recurrence nor of any mechanical disturbance throughout the digestive tract. There has been no further ulcer pain, his weight is maintained and he is highly pleased with his operation. Nevertheless, bloating, nausea and vomiting are said to follow any but small meals. Diarrhoea recurs in spells and dizziness and weakness follow attempts to do any but light work. This former steeplejack and Air Force steward is living on public relief in a rural community where he maintains there are no light jobs. Although he admits vast improvement since his operation he is afraid to drop his relief and take a chance on making his way in town or city. This psychological invalidism is encountered in some other examples of the "dumping" or post-gastrectomy syndrome.

Comment

It should be emphasized that the follow-up period of 14-50 months in this study renders the latter an interim report only. Further time must elapse in order to judge the efficacy of this method. Elsewhere articles of a conflicting nature concerning vagotomy are appearing. The most favorable reports come from Dragstedt² of the University of Chicago and from Crile⁴ at the Cleveland Clinic. A smaller series with good results has been published by Ross³.

It is gratifying to find in our small series of stoma ulcers that vagotomy has been effective in the management of so serious a complication. Moreover to our knowledge at the present time no such lesion has occurred among our cases of gastroenterostomy with vagotomy.

One of the chief weaknesses in the procedure of vagotomy will continue to be the difficulty in resecting all of the vagus nerve fibres. This is due to the varying anatomical arrangement of the nerves which will prevent a complete demonstration of all the fibres in some cases. This proportion should vary with the experience of the operator,

but even the most experienced admit that in certain cases (less than 10 per cent) complete section of all the vagus fibres is impossible short of complete trans-section of the oesophagus.

Conclusions

1. The results following vagotomy alone or combined with another procedure in 98 cases have been assessed one to four years postoperatively.

2. Vagotomy alone, or vagotomy combined with gastric resection has not proved satisfactory in the surgical management of duodenal ulcer.

3. Vagotomy alone has been quite satisfactory in the surgical management in five cases of jejunal ulcer.

4. Vagotomy combined with gastroenterostomy in the management of 37 cases of chronic duodenal ulcer has provided complete relief in 72% and satisfactory relief in over 95% for one to four years postoperatively.

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CASE HISTORIES—SURGICAL

Hypernephroma of Kidney Nephrectomy

S. S. Peikoff, M.D., F.R.C.S. (Ed.),
F.R.C.S. (C.), F.A.C.S.

This is the eleventh of a series of Case Histories which will appear in the Review each month. The purpose of these publications is not to present rare or unusual cases but rather to consider the routine management of common surgical conditions.

Case No. 47-933. Mr. N.D., St. Boniface Hospital. Color, white. Age, 58 years. Occupation, watch maker. Date of admission, January 6, 1947. Date of operation, January 15, 1947. Date of discharge, January 27, 1947.

Complaint on Admission

1. Swelling in left side of scrotum, 5 months.
2. "Dragging feeling" in left side of scrotum, 5 months.

Present Illness

Early in August, 1946, patient noticed a "dragging feeling" in the left groin and observed that the left side of his scrotum felt somewhat larger than previously. This heavy feeling was worse when he was on his feet for a time or when walking and was eased when lying down. He also noticed an increased feeling of weakness and tiredness over the past number of months. His impression was that he had a "rupture."

Inventory by Systems

Eyes—Vision good. No diplopia or blurred vision.

Ears—Hears well. No tinnitus or vertigo.

Respiratory—Occasional "head cold." Some dyspnoea on moderate exertion. No pain in chest. No cough, expectoration or haemoptysis.

Cardio-vascular—No history of rheumatic fever or syphilis. Dyspnoea on moderate exertion. No palpitation, substernal pain or ankle oedema.

Gastro-intestinal—Appetite usually good but has noticed some decrease during past 6-8 months. Has some epigastric discomfort and "belching" after a heavy meal. No nausea or vomiting. Bowels tend to be constipated; uses mineral oil. No melaena. No history of jaundice.

Genito-urinary—No frequency. Nocturia 1 time for past 1-2 years. No burning or pain on micturition. Passed gross blood in urine on November 1, 1946, and again on November 3, 1946. This symptom was not mentioned until the patient was thoroughly questioned.

Nervous system—Sleeps well. No headaches. No change in motor or sensory abilities.

Musculo-skeletal — Increasing weakness 6 months. Occasional boring pain in left loin.

Metabolic—No heat or cold intolerance. Loss of weight (140 pounds to 132 pounds) since March 1946.

Past History

Measles during childhood. Influenza, 1918. Diphtheria, 1918. Hemorrhoidectomy, 1934. No other illnesses, operations or accidents.

Family History

Mother—Died at 73 years of age—old age.

Father—Died at 100 years of age—senility.

Three brothers—Alive and well.

No family history of cancer, diabetes, tuberculosis, epilepsy, mental disease, etc.

Physical Examination

General Impression — A short, tired-looking white male, about 60 years of age, most co-operative but rather nervous and jittery.

Head and Neck:

Cranial nerves—Intact.

Eyes—Lids, conjunctivae, corneae and lenses normal. Pupils equal, round, react to light and accommodation. Ocular fundi normal.

Ears—External ears, canals and tympanic membranes normal.

Nose—No obstruction, mucosa normal.

Lips, gums, tongue—Show no pathology.

Teeth—Dentures.

Throat—Tonsils slightly hypertrophied and contain purulent material.

Neck—Palpable submandibular glands. No other lymphadenopathy. Thyroid not palpable.

Chest:

Heart—Apex beat not visible or palpable.

Heart sounds regular, good quality, rate 72 per minute. No murmurs. Blood pressure 150/90.

Lungs—No chest deformity. Movements equal and symmetrical. Tactile fremitus good. No dullness on percussion. Breath sounds good. A few coarse rales at right lung base posteriorly which disappear after coughing.

Abdomen—slight fullness in left upper quadrant on inspection. Liver and spleen not palpable. There is a rounded grapefruit-sized mass occupying the left upper quadrant of the abdomen which is slightly tender on palpation. Reflexes present and equal.

Genitalia—Small left indirect inguinal hernia. Moderate-sized left varicocele which disappears very slowly on lying down. Left testicle slightly larger and slightly softer than right one.

Rectal examination—Sphincter tone good. Prostate not enlarged or tender. No new growth felt.

Extremities:

Upper—No deformity or wasting. Movements good. No clubbing of fingers.

Reflexes	Right	Left
Biceps	†	†
Triceps	†	†
Supinator	†	†

Lower—No deformity or wasting. Movements good. Arterial pulsations good. Vibration sense intact.

Reflexes	Right	Left
Knee	†	†
Ankle	†	†
Plantar	V	V

Clinical Laboratory

Urinalysis—January 7, 1947. Urine turbid, straw-colored. Reaction alkaline. Specific gravity 1.023. Albumin, 0. Sugar, 0. Microscopic, 5-6 pus cells per h.p.f. No red cells or casts.

Blood Count—January 11, 1947. Red blood cells, 4,710,000. Hemoglobin, 82%. Color Index, 0.87.

Hemoglobin—January 26, 1947, 84%.

Pyelogram—January 7, 1947. Intravenous pyelogram. Visualization is not entirely satisfactory, partly because of gas in small bowel. The right side shows no gross abnormality. There is some dilatation of calyces on left side. A defect in

the floor of the bladder suggests enlargement of the prostate.

January 9, 1947. Retrograde pyelogram—The outline of the right kidney can be partially seen. The left kidney outline cannot be discerned, but the left half of the abdomen has a cloudy appearance, suggesting the presence of a soft tissue mass. The left pelvis is bifid and the calyces of the upper part are dilated. The inferior calyx of the lower part shows marked cupping, suggesting enlargement of the papilla. These features are considered evidence of a left kidney tumor. The calyces of the right kidney are dilated. No shadows are seen to suggest calculi.

X-ray chest—January 13, 1947. Single P.A. film of chest. Diaphragms are normal. The cardiac shadow is moderately enlarged. The lung fields appear clear.

Pre-operative Diagnosis

1. Left renal carcinoma.
2. Left varicocele produced by pressure on spermatic vein by tumors.
3. Left indirect inguinal hernia.

Indications for Operation

The presence of a kidney tumor which is probably malignant.

Pre-operative Care

The patient was placed on a high protein, high carbohydrate diet supplemented by amino-acids and multi-vitamins for several days prior to operation.

The patient was grouped and matched for blood transfusion and whole blood taken to the operating room.

Detailed Description of Operative Technique and Operative Findings

Position—Patient placed on his right side with pillow in the intercosto-iliac space at which point the table is broken. The right leg was flexed and the left extended. Braced in position. Incision—commenced at the angle between the 12th rib and outer border of the erector spinae, passing obliquely downward and forward toward a point about an inch medial to the anterior superior spine and then parallel to Poupart's ligament for about 1½ inches. Incision passed through skin, superficial fascia, the posterior layer of lumbodorsal fascia, the anterior fibres of the latissimus dorsal and the posterior fibres of the external oblique. These muscles were divided in the line of incision. The upper part of the serratus posterior inferior lying under the latissimus dorsi was divided when the fibres of the latissimus dorsi were cut. The internal oblique was divided at right angles to its fibres; and finally the posterior aponeurosis of the transversalis muscle. The 12th nerve and vessels just under the 12th rib were retracted upwards.

The inner border of the quadratus lumborum was incised for about one inch and retracted medially; the transversalis fascia was then divided and the wound well retracted. With a haemostat an opening was made into the fatty capsule of the kidney and with the hand and fingers the kidney was separated by blunt dissection. Bands were carefully clamped, cut and ligated. The lower portion of the left kidney was immediately felt to be the size of a grapefruit and had an irregularly lobulated feel. Separation of perirenal fat was somewhat difficult in this region. The upper pole was easily separated from its fatty bed. Particular care was taken to manipulate the kidney very gently in order to prevent dissemination of the new growth. After the kidney was freed on all sides delivery into the wound was difficult. The wound was therefore increased in size by dividing the external arcuate ligament, which extends from the transverse process of the 1st lumbar vertebra to the tip of the twelfth rib. The lower pole of the kidney was then gently drawn downwards into the wound and gradually displaced outwards. Special kidney-seizing forceps were not used.

The ureter was pulled up from its bed for about 4 inches, clamped, cut, ligated and treated with phenol and alcohol. The peritoneal cavity, containing the descending colon, spleen, etc., was retracted medially and the kidney pedicle with its paravascular lymphatic tissue was separated for about 2½ inches. A chromic catgut No. ii ligature was placed around the pedicle en masse, relieving tension on the pedicle while the ligature was firmly tied. Two right-angled kidney pedicle clamps were then applied lateral to the ligature, the pedicle divided distal to them, and the kidney placed in a specimen basin. There was no gross malignant invasion of the renal vein demonstrable at operation. The pedicle was then transfixed with a chromic catgut No. 2 suture-ligature, which was firmly tied as the clamps were removed.

The cut margins of the muscles and fascia were then approximated with interrupted sutures of chromic catgut No. 1 after a rubber Penrose drain had been placed in the renal space and brought out through the posterior angle of the wound. The skin was approximated with interrupted mattress sutures of silkworm gut.

The wound was covered with a large dressing bound down with elastoplast.

Anaesthetic

Nembutal gr. 1½ given evening before operation, and gr. ii given morning of operation. Morphine gr. 1/6 with atropine gr. 1/150 given hypodermically 1 hour before operation.

Before Induction—Temperature, 99.2° F. Pulse, 96. Respiration, 30. Blood pressure, 140/80.

Agents—Cyclopropane. Ether, ½ oz.

Technique—Closed. Patient intubated.

Stimulants—500 cc. whole blood during operation.

Post-operative Condition—Good. Pulse, 128. Respiration, 15. Blood pressure, 100/70.

Gross and Microscopic Description of Tissues Removed

Left Kidney—Gross: Lower 2/3 of left kidney occupied by a grapefruit-sized mass, 12 cms. in greatest diameter. Weight 875 gms. Surface nodular and bluish in color. Cross-sections show typical variegated appearance of hypernephroma—haemorrhagic areas and islands of ochre-yellow tissue with a few small cysts. Large main trunk of renal vein not invaded.

Microscopic: Typical histology of hypernephroma or clear-cell renal carcinoma. Sections show areas of necrosis, hemorrhage and fibrosis.

Final Diagnosis

1. Left clear-cell renal carcinoma.
2. Left varicocele secondary to pressure of spermatic vein by kidney tumor.
3. Left indirect inguinal hernia.

Progress Notes Including Post-operative Care During Stay in Hospital

January 15, 1947—Returned to ward from operating room. Pulse 128, weak and rapid. Respiration 32. Looks pale. Transfusion of 500 cc. whole blood started, but patient chilled so transfusion stopped.

Doctor's orders: 1. Penicillin 30,000 units I.M. OH 3. 2. CO₂ hyperventilation every hour for six times, then q.i.d. 3. Morphine gr. ¼ p.r.n. for pain. 4. Oxygen continuously by nasal catheter.

6.45 p.m.: Blood pressure 75/50. Pulse 135. Transfusion of 500 cc. whole blood started—all absorbed. Blood pressure 80/60. Pulse 130. Post-operative night.

January 16, 1947—Temperature 101.3° F. Pulse 120. Respiration 25. Blood pressure 98/75. Patient appears much brighter. 1000 cc. 5% glucose in saline given intravenously. Taking fluids liberally by mouth. Penrose drain shortened. Spent a fairly good night.

January 17, 1947—Temperature 99.3° F. Pulse 110. Respiration 20. Blood pressure 115/80. Patient sitting up in bed. Condition appears good. Penrose drain shortened. Spent a good day and night.

January 18, 1947—Patient up out of bed and walking. Feeling much improved. Penrose drain shortened. 1000 cc. 5% glucose in saline given intravenously to maintain adequate fluid intake.

January 19, 1947—Penrose drain removed. 1000 cc. 5% glucose in saline I.V. Condition good.

January 20, 1947—1000 cc. 5% glucose in saline I.V. Condition good.

January 22, 1947—Penicillin discontinued.

January 25, 1947—Sutures removed. Wound
erawell healed.

January 27, 1947—Discharged from hospital.
12 Feels weak but condition appears favorable.
Temperature 97.2° F. Pulse 72. Respiration 20.
Blood pressure 130/80. Varicocele has become
much smaller in size.

Condition on Discharge

Recovered. Prognosis guarded.

Follow-up Notes Since Leaving Hospital

Following his discharge from hospital the
patient did not fare well. He was seen several
times, both at the office and at home, and com-
plained of intermittent pain in the left loin, pro-
gressive weakness, and poor appetite. He pursued
a fairly rapid down-hill course and died at home
in June, 1947.

Consent for an autopsy was not obtained.

MEDICINE

Recent Advances in Internal Medicine

This is the Third of a series of articles on Recent Advances
in Medicine

Integration of Metabolism

S. Vaisrub, M.D., M.R.C.P. (Lond.)

In harmony with the general trend toward
elimination of artificial barriers in Medicine and
Biology is the gradually emerging integrated view
of metabolism. This view owes its development in
in a large measure to researches into intermediate
metabolism of foodstuffs with the aid of radioactive
isotopes. As a result of these studies, many lines
of demarcation, both within the framework of the
individual groups of nutrients and in the sphere of
their inter-relationships, have been rendered faint
and almost non-existent.

As an outstanding example of this change may
be cited the present concept of protein metabolism.
The old subdivision of proteins into the ingested,
exogenous, and the endogenous, tissue proteins,
and the view, that important metabolic changes
occurred only in the former, while the metabolism
of the latter was restricted only to "wear and
tear," has now been abandoned. Studies with
radioactive isotopes (Schoenheimer, 1942) have
demonstrated that all proteins, whether exogenous
or endogenous, undergo continuous breakdown and
synthesis. Plasma proteins, hemoglobin, intra-
cellular proteins, antibody proteins all undergo
anabolic and catabolic changes at various rates of
turnover. (As much as half the protein of the liver
is resynthesized in ten days). Active breakdown
occurs even during periods of nitrogen equilibrium
and resynthesis during starvation. Synthesis is no
longer thought of as a mere replacement of loss of
"wear and tear," but as a continuous dynamic ex-
change between proteins and the substances in the
"metabolic pool," which consists of substances
derived from catabolic processes in the tissues as
well as substances absorbed from the intestine.
Nor is there "storage" protein as distinct from
"fixed" proteins. All proteins are in a state of
flux, labile and rapidly removable. They may be
drawn from one tissue to another to supply a

deficiency. They may even, according to some
authorities (Schmidt, 1938) occasionally inter-
change directly without preliminary breakdown to
amino acids.

Similarly, as a result of isotope studies, the
concept of "static" tissue fats had to be discarded,
for it has been demonstrated (Schoenheimer) that
tissue fats are in a continuous state of flux, being
continuously replaced by dietary fats. Even on a
fat free diet some of the ingested fat is stored, and
some of the stored fat is utilized.

Recent investigations have also altered the con-
cept of the inter-relationship of the metabolism of
carbohydrates, proteins, and fats. The previously
held view, that the body cells possess independent
individual mechanisms for the metabolism of the
three major foodstuffs, had to be modified. Isotope
studies have demonstrated that at the level of the
tricarboxylic acid cycle and at lower levels of
carbohydrate metabolism the intermediate prod-
ucts of the breakdown of carbohydrates, proteins,
and fats are interchangeable. Each of the three
nutrients supplies fragments to a common "meta-
bolic pool," from which they can be drawn, and
into which they can be released by body tissues.
Since it is at these levels of intersection that the
major part of the energy used by the biological
systems of the body is liberated, one can hardly
speak of separate pathways of metabolism except
with reference to the preliminary stages.

It is as yet too early to foretell the practical
applications of the emerging highly integrated
view of the dynamic balance of metabolism. Per-
haps the prediction could be ventured that one of
its results will be a more rational and sceptical
attitude toward the various dietary fads currently
popular. In view of the interchangeability of the
products of metabolism, some of the claims made
for these rigid dietary regimes, may appear some-
what questionable.

Whatever the immediate practical applications,
there is little doubt that a unified co-ordinated
concept of the fundamental processes of the body
in health, will contribute greatly to the under-
standing of their derangements in disease.

Biological Competition of Structural Analogues

A brief reference has already been made in the present review* to the integrated concept of therapy evoked by the discovery of the effects of cortisone and ACTH in various disorders. A similar search for unifying general principles has been in evidence in fields of therapeutics and pharmacology. Of the concepts evolved, few have been more important and fruitful than the concept of biological competition as applied to the action of drugs. Associated with the names of Woods and

of research by sulphonamide therapy, has helped shed more light on the action of drugs other than the sulphonamides. As an example may be cited Dicoumarol, which was shown (Witts, 1942) to be structurally related to Vitamin K. It was suggested that Dicoumarol exerts its effect by interfering with the utilization of Vitamin K by the liver. A similar structural relationship has been demonstrated (Krantz and Carr, 1949) between histamine and the anti-histaminic drugs.

More important than the above "retrospective

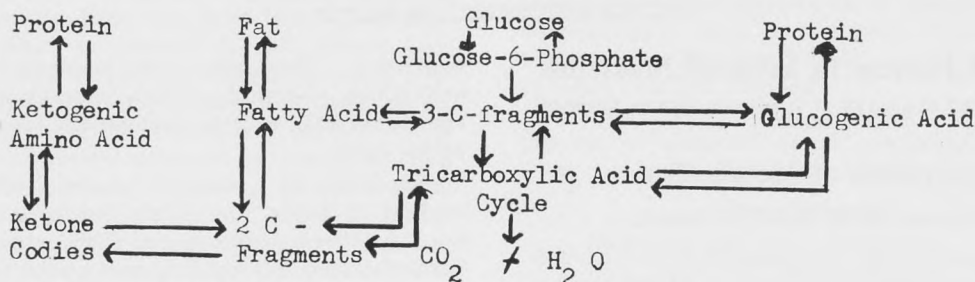


Figure 1 - Fusion of Metabolism.

Fildes, this hypothesis proved to be a great stimulus to therapeutic research productive of many practical results.

The basis of this theory is the principle of biological competition between structurally related compounds for a vital cell enzyme. Applying this principle to the action of Sulphonamides, Woods (1940) and Fildes (1940) have suggested that the antimicrobial action of sulphonamides is due to their structural similarity to Para-aminobenzoic Acid (PABA), a metabolite essential for the growth of certain bacteria.

application of the theory of substrate competition to the explanation of the actions of known drugs is its application to the synthesis of new analogues and their experimental trial in disease. Many antimicrobial substances have been synthesized, as well as others with effects in non-bacterial diseases. Outstanding examples are Aminopterin and other folic acid antagonists used in the treatment of Acute Leukemia (Farber, 1948).

Despite the spectacular practical results of this concept of competitive inhibition, and the attractiveness of its simplicity, it still remains a hypothesis, based on inference rather than conclusive evidence. The fact that many antibacterial substances are antagonized by "essential metabolites," structurally related to them, does not necessarily imply that they exert their action by displacement of these metabolites through competition for a vital enzyme. The mode of action is still open to question. Nor has the application of this hypothesis to individual groups of drugs gone unchallenged. Woods himself has recently conceded that the inhibition of bacterial growth by sulphonamides cannot be satisfactorily explained solely by their effect on the synthesis of folic acid. These considerations, however, do not by any means detract from the value of this concept. Whether the theory be right or wrong, it is productive of results. Moreover it has the added significance of being one of the heralds of an era in therapeutic research, in which deductive reasoning and a rational approach based on theoretical concepts will play a part as important as empiricism and good fortune have in the past. Although based on facts and observations, theories have the habit of "outrunning" them, and guiding research and medical thought

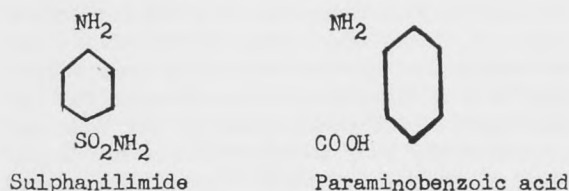


Figure 2.

According to this theory, sulphanilimide, by virtue of its structural similarity to PABA, displaces this essential metabolite from some enzyme system vital for the growth of the organism, thus causing bacteriostasis. The nature of the metabolic mechanisms involved has been further elucidated by the discovery of structure and synthesis of folic acid, (Angier et al, 1946). The latter was found to consist of PABA, glutamic acid, and the pterin ring. It was suggested that sulphonamides act on certain bacteria by preventing the synthesis of folic acid from PABA.

The extensive study of structural analogues, consequent upon the impetus given to this type

and thus enriching medicine. The concept of biological competition of analogues is a case in point. It represents an important recent advance.

Trends in Therapy

Ours is the Golden Age of therapeutics. Living in it, we lack perspective for the proper assessment of the progress that has been made. Sulphonamides, Antibiotics, anticoagulants, steroid hormones, folic acid antagonists, anti-histamines, and a host of other drugs have enriched therapeutics beyond the dreams of past generations. Not unlike the nouveau riche, flaunting his newly acquired wealth, the physician of today often tends to be somewhat ostentatious and lavish in its use. His overenthusiasm is fully reflected in the medical literature which abounds in glowing reports of therapeutic achievements with various drugs.

Counsels of restraint, however, are beginning to be heard in various quarters. They emphasize the factor of suggestibility in the patient, which renders objective evaluation of drug action extremely difficult. Wolfe (1950) describes marked changes in gastric secretion and motility, observed directly, after administration of innocuous substances uncoupled with suggestion. Similar findings in the colon were observed by Almy and his co-workers (1950). Quinn and Mason (1950) in their studies of Desoxycorticosterone and Ascorbic acid in arthritis, and Cowen and Diehl (1950) in theirs of Antihistamines in the treatment of the common cold, have duplicated the effects of these widely publicized drugs with placebos. These workers make a plea for better controls in the clinical trial of drugs, and for cautious scepticism in the interpretation of results, as safeguards against overenthusiasm and subsequent disillusionment.

The above counsel of caution, however, is not meant to detract from the imposing overall panorama of recent triumphs in therapy, triumphs based not only on discoveries of new drugs, but also on the emerging better knowledge of man. New concepts, founded on studies of heredity, constitution, responses to stress, and the interrelationship between the psyche and the soma, have led to better understanding of man in health and in disease, and indirectly to more rational therapy. Medicine has widened its horizons. It has learned to borrow heavily not only from the allied disciplines of pathology and physiology, but also from genetics, biology, psychology, sociology, art and philosophy. The extensive interdisciplinary exchanges and co-ordination of information has helped to evolve a more integrated concept of therapy, directed toward aiding the innate defensive and adaptive mechanisms of the soma and psyche, mechanisms which are goal directed and operate to maintain the integration of personality. This concept of therapy, labelled

by some humanistic, by others holistic, represents, perhaps, the greatest recent advance in medicine.

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UROLOGY



Haematuria and Its Significance

Melville J. Swartz, M.D.

Macroscopic haematuria may be due to a great variety of conditions and generally signifies some serious pathological condition of the urinary tract. It is most startling to the patient and as a rule little time is lost in getting to a physician. It is not a clinical entity which requires treatment, but a symptom which demands investigation. Unfortunately many physicians are unalert to the potentially serious diseases which this symptom may herald. Failing in this, invaluable time and often opportunity to save a life is lost.

Although most haematurias are due to some surgical lesion of the genito-urinary tract, we must not lose sight of the fact that certain drugs such as the sulphas, urotropine, Phenol, sodium salicylate, turpentine, and others may cause haematuria. Extra genito-urinary conditions which may cause haematuria as well, are such conditions as acute and chronic nephritis, haemorrhagic diseases of the new born, uric acid infarction in infants, haemophilia, scurvy, purpura, sub-acute bacterial endocarditis, acute rheumatic carditis, severe renal passive congestion, leukemia, bilharzia, trauma, sepsis, appendicitis, severe physical exercise and exposure to cold.

So called essential haematuria is not an entity and such idiopathic cases today most often are recognized as being caused by chronic unilateral or bilateral glomerular nephritis, arteriosclerotic nephritis, chronic passive congestion of the kidney, varices of the renal papilli, lead poisoning, renal infarction and embolism and causes outside the urinary tract. In a thorough clinical study done recently, it was found that the majority of cases

of bleeding for which no local causes could be found, occurred in the fourth decade, a period when vascular changes might well account for many cases.

In a careful analysis of haematuria by a number of authors it was found that as a rule haematuria is caused in sixty-five to seventy per cent of cases by calculi, tuberculosis, cancer, or other surgical conditions of the kidney; while the other thirty to thirty-five per cent most certainly require a thorough investigation. The great importance in subjecting these patients to a thorough examination is at once apparent. With the present day

methods of diagnosis the origin and cause of urinary haemorrhage can be ascertained in a very large percentage of cases.

It is not the writer's intention to list the causes of haematuria, and suffice it to say these can be found in any good urological text. But it is the intention to point out that red blood corpuscles have no place in normal urine, and that their presence is caused by some pathological condition which it is our duty to discover, and that routine urological investigations seldom will fail to reveal the local causes of haematuria, which to the general clinician, must otherwise remain a closed book.

CASE REPORT

Splenic Anaemia and Cholelithiasis*

Leonora Hawirko, M.D.

The patient, a woman, 33 years of age, was admitted to the hospital on November 11. A few days previous to admission she had a typical attack of biliary colic with pain in the right upper quadrant, chills, jaundice and clay colored stools. She had a similar attack in September, 1948. In 1940 she was at the St. Boniface Hospital. She was admitted with jaundice of three weeks' duration. Her blood was down at that time. She had a cholecystectomy done and made a good recovery. At the time of operation she had an enlarged liver and spleen. She was given iron and injections of liver for two years after that. Since then she has had some dyspnea on exertion. She was also unable to eat fatty foods. At times she was a little jaundiced especially when tired and occasionally noticed some itchiness of her skin. About June, 1948, she began having nose-bleeds which have been present off and on since—occasionally from one side and at other times from the other. For the past two months this has occurred almost every day. She has never had an attack simulating a hemolytic crisis—i.e. fever, palpitation, dyspnea followed by an increase in jaundice. No pain in the limbs. She did not have anaemia or jaundice in childhood.

She was born in Manitoba and has only been out of the province once to Chicago.

Family History

Father died of cancer of liver at age of 69. Mother has diabetes. One child died at 5 weeks (cause unknown). No family history of jaundice or anaemia.

Physical Examination

A young, healthy looking woman who did not appear ill. Spleen palpable to umbilicus—liver 1

finger width below the costal margin. There was no pigmentation of the skin, no superficial veins and the glands were not palpable. Otherwise physical examination was negative. B.P. 110/70. It was interesting to note in looking over the records in 1948 that the spleen was described as being a hand's breadth below the costal margin and the liver one finger's breadth—in other words there has been an increase in the size of spleen and liver in the past two years.

Gall Bladder visualization showed a non-functioning gall bladder with stones. Chest x-ray negative.

Laboratory Investigation

November 15—Urinalysis, negative. Hb, 65% Rbc, 2,900,000. Wbc, 2,500, P 34, L 60, M 4, E 2.

Smear, showed no abnormal cells, no spherocytes. Platelets, 328,000. Sed. rate, 130 mm. in 1 hour. Reticulocytes, nil. Icterus Index, 38. Coombs Fragility, hemolysis begins .46%, ends .40. Fr. HC1, 10-15-25-35-15. Urine, faint trace of bilirubinogen, positive 1:180. W.R., negative. Bone marrow, immature red blood cells are increased from a normal of 20% to 30%.

There was also a maturation arrest of the leucocytes.

November 27—Icterus Index, 18. Reticulocytes 1%. Sed. rate, 75 mm. in 1 hour. Coombs test negative.

In looking over the laboratory findings of the blood count the color index is reported as being over 1. I feel that there must be some error here either of the Hb. or the red blood count as the smear shows no variation in the size of the cells and no macrocytes. Therefore this anaemia is hypochromic in type. The salient features in the patient are:

- (1) Anaemia—Hypochromic.
- (2) Leucopenia.
- (3) Normal platelet count.
- (4) Normal cell fragility.

*Presented at Clinical Luncheon at St. Joseph's Hospital, Winnipeg.

- (5) Moderately enlarged spleen (10 years).
- (6) Slightly enlarged liver (10 years).
- (7) Jaundice—increased icterus index.
- (8) Increased urobilinogen in urine.
- (9) Epistaxis.
- (10) Cholelithiasis.

The presence of the gall stones in this patient is indeed a problem. Are they definitely caused by the same condition that causes the splenomegaly i.e. haemolytic anaemia. Or are the gall stones simply a "red herring"—i.e. does this patient have gall stones and a blood dyscrasia. She was admitted to hospital on two occasions shortly after an attack of biliary colic which could have caused the jaundice. Therefore in the differential diagnosis one must consider not only the conditions which present splenomegaly with jaundice but also those which present splenomegaly without jaundice.

In the differential diagnosis one had to consider the following:

- (1) Pernicious anaemia.
- (2) Gaucher's disease.
- (3) Felty's syndrome.
- (4) Aleukemic myelogenous leukemia.
- (5) Syphilis.
- (6) Hemolytic anaemia, congenital, acquired.
- (7) Splenic anaemia.
- (8) A few rare conditions which can be easily ruled out e.g., (a) Sickle cell anaemia—only occur in negroes; (b) Chronic malaria, Mediterranean anaemia and Kala Azar—do not occur in Canada; (c) Nieman Pick's, Schuller Christian disease—only present in children.

Let us consider each of these diseases separately starting with the ones that can be ruled out easily first.

1. Pernicious Anaemia

A chronic disease characterized by an insidious onset and marked by:

- (1) Age usually over 40—rarely under 30.
- (2) Certain gastro-intestinal and neurological disturbances.
- (3) A sore tongue is very common.
- (4) Achylia gastrica.
- (5) Enlarged spleen—a decided enlargement is unusual.
- (6) Macrocytic anaemia.
- (7) Leukopenia.
- (8) Evidence of blood destruction.
- (9) Bone marrow is megaloblastic.

This patient has three of the features of pernicious anaemia. Leucopenia, evidence of blood destruction and splenomegaly. The age is against it as she first had an enlarged spleen at the age of 23. She has no gastro-intestinal or neurological disturbances which are present in 70-75% of cases, no sore tongue which is present in 58% of cases. The anaemia is a normocytic, hypochromic and not

macrocytic. Also the size of the spleen is too large for this condition. The patient has acid in the stomach and in pernicious anaemia the achlorhydric occurs in 97.6% of the cases. Finally the bone marrow does not show the megaloblastic reaction typical of pernicious anaemia so I feel that you can safely rule it out.

2. Gaucher's Disease

Definition—a rare familial disorder characterized clinically by:

- (1) Splenomegaly.
- (2) Skin pigmentation.
- (3) Pingueculae.
- (4) Bone lesions.

Symptoms

(1) Usually appears early in life but may not appear till adult life.

(2) Splenomegaly is the outstanding feature—the increased weight or severe pain in the splenic area caused by a splenic infarct may bring the patient to the doctor.

(3) Haemorrhage from the nose and gums is common.

(4) Brownish skin pigmentation — 45-75% of cases.

(5) Pingueculae—light yellowish brown areas of discoloration on the sclera.

(6) Blood:

(a) Anaemia of normocytic type.

(b) Leucopenia with relative lymphocytosis.

(7) Bone lesions—cause pain in the limbs. X-ray shows a mottled appearance of the lower part of the femur.

(8) No evidence of blood destruction.

(9) Gaucher cells are found in the sternal marrow.

This patient has the splenomegaly anaemia, leucopenia and nose bleeds. She does not have the skin pigmentation or pingueculae and does not complain of pain in the limbs. These features are occasionally absent in Gaucher's disease but the sternal marrow in this case rules out the condition.

3. Felty's Syndrome

Is a condition in which there is rheumatoid arthritis, anaemia, splenomegaly, leucopenia and achlorhydria. The absence of arthritis and presence of HCl in stomach easily rules out this condition.

4. Aleukemic Leukemia (Myelogenous)

In this condition the symptoms and signs of myelogenous leukemia are present but the white blood cells are normal or subnormal in number. As a rule the blood smear shows some immature cells. The bone marrow shows a typical picture of myelogenous leukemia. In this condition the spleen is enlarged, glands are not palpable—there is an anaemia with all the symptoms caused by it.

There may be haemorrhage from the nose. The findings in the bone marrow in this case definitely rules out aleukemic leukemia.

5. Syphilis

Ruled out here by a negative W.R.

6. Congenital Haemolytic Jaundice

Definition: A chronic congenital often familial disease characterized by

1. Variable degree of anaemia of the hemolytic type.
2. Splenomegaly.
3. Diminished resistance of red blood cells to hemolysis by hypotonic saline.

Symptoms and Signs

(1) Onset—symptoms may appear at birth or shortly afterwards or because of the mild degree of symptoms which may pass unnoticed the disease may not be diagnosed till adult life. Because in some cases the symptoms are so mild a negative family history should not be accepted unless the relatives are examined.

(2) There may be no complaints and only a slight jaundice and no anaemia.

(3) A slight dyspnea on exertion may be the only complaint.

(4) A crisis which is due to a sudden increase in blood destruction may cause the first symptom the patient has—i.e. fever, palpitation or violent abdominal pain with vomiting and anorexia.

(5) An attack of biliary colic may bring the patient to the physician. Gall stones have been found in 68% of the cases. In the Mayo series gall bladder disease was found in 71% of cases.

(6) The spleen is enlarged and may be huge.

(7) Liver—may or may not be enlarged but is never very large—1-3 cms. below the costal margin.

(8) Nose bleeds are common but haemorrhage from other parts of the body does not occur.

(9) A rare complication is a chronic leg ulcer which occurs over the external or internal malleolus. This may be the patient's only complaint and does not heal unless a splenectomy is done.

(10) Abnormalities in the skeleton and other developmental anomalies e.g. "tower skull," excessive number of digits. Thickening and striation shows up on x-ray and is caused by continuously stimulated haematopoiesis on bone formation.

Laboratory Findings

The findings in the blood and urine are directly related to the rate and degree of blood destruction.

(1) Bilirubin accumulates in the blood stream due to blood destruction. The amount depends not only on the extent of blood destruction but also on the liver capacity of removing the pigment from the blood stream and excreting it in the bile.

In hemolytic anaemia the function of the liver is impaired by degenerative changes in the liver epithelial cells due to anoxemia produced by the anaemia. This gives:

(a) High icterus index.

(b) Positive indirect Van Den Berg.

(2) Urobilinogen is in urine and faeces in large amounts.

(3) Blood count and blood smear.

(a) There may be no anaemia.

(b) Anaemia is usually normocytic—if immature cells are numerous you may get a macrocytic anaemia.

(c) Reticulocytes, 10-25%.

(d) Anisocytosis, Polychromatophilia and Normoblasts may be present.

(e) Spherocytes—these cells are spherical in shape and can be identified by the bizarre type of rouleux formation.

(f) Leucocytes—usually leucocytosis, in certain cases leucopenia.

(g) Platelets—normal, increased or decreased.

(4) Fragility of red blood cells when suspended in hypotonia is greatly increased. This is because the spherical cells need to absorb very little fluid to stretch the membrane to the bursting point. Increased fragility is not found it may some time be demonstrated by first washing the cells with saline. A control test of normal blood should always be made.

(5) Bone marrow is hyperplastic of the normoblastic type. There are no megaloblasts or atypical normal leucocytes. In some cases in the quiescent phase the bone marrow does not give much information.

(6) Coombs test which is used to differentiate between congenital and acquired hemolytic anaemia is positive. This test if positive demonstrates the presence of circulating antibody. Antihuman globulin serum obtained by injecting human cells into rabbits is used for the test. A negative test rules out hemolytic anaemia.

Acquired hemolytic anaemia—has the features of congenital hemolytic anaemia although the anaemia is usually more severe. The onset is in early adult life.

The cell fragility may be normal and the spherocytes only slightly increased—the other findings are the same as in the congenital type. However there are many features in this case that would rule out haemolytic anaemia either of the congenital or acquired type.

(1) The cell fragility is normal. This definitely rules out congenital hemolytic anaemia but in the acquired type the cell fragility may be normal.

(2) No spherocytes were present in the smear. This is always present in the congenital type and in the acquired type this is usually increased from the normal.

(3) Reticulocytes are not increased. This is a very important point against hemolytic anaemia as with hemolysis there is always an increase in the reticulocyte count.

(4) Leucopenia—leucocytosis is usually present in hemolytic anaemia.

(5) Bone marrow is not of the normoblastic type.

(6) Coombs test is negative.

The only definite evidence pointing to haemolysis in this case is an increased urinary urobilinogen which could be caused by liver disease. In order to find out if the increased urinary urobilinogen is due to hemolytic anaemia or liver disease one should do a faecal urobilinogen. This was ordered in this patient but was not done because technically it is a rather complicated procedure. In hemolytic anaemia the faecal urobilinogen is greatly increased. I feel, however, that from the above information one can rule out hemolytic anaemia in this case.

7. Splenic Anaemia—Signs and Symptoms

(1) Age of onset is usually under 35. Females are affected twice as frequently as males.

(2) The onset is usually insidious but it may come on suddenly with the passing of a large tarry stool or vomiting of blood. Gastro-intestinal haemorrhages occur in one-half of the cases and nose-bleeds in one-third.

(3) The spleen is always enlarged and this enlargement sometimes may precede the anaemia.

(4) The only symptom the patient may present is discomfort from an enlarged spleen.

(5) If the anaemia is marked, dyspnea on exertion and weakness may be present.

(6) There may be a moderate enlargement of the liver and in some cases cirrhosis. The disease may run a prolonged and often benign course and may appear to be arrested with the patient having no complaints at all, but at any time haemorrhage may occur. Death occurs from haemorrhage of hepatic insufficiency.

Laboratory Findings

Blood

(1) Unless haemorrhage has occurred the anaemia is moderate—usually hypochromic microcytic.

(2) Leucopenia is the most constant feature—the distribution is normal.

(3) Platelets—often reduced but may be normal. Bone marrow—in the early stage it is normal—later it may show a normoblastic hyperplasia.

Cell Fragility is normal.

This patient has many features to suggest splenic anaemia.

(1) Age is under 35.

(2) Insidious onset present for 10 years.

(3) Nose bleeds—occur in 1/3 cases.

(4) Enlarged spleen.

(5) Enlarged liver.

(6) Anaemia—hypochromic.

(7) Leucopenia.

(7) Normal platelets.

There are a few features that do not fit in with splenic anaemia. However an adequate explanation is put forth for these.

(1) Jaundice and increased icterus index—This may, however, be caused by the gall stones.

(2) Presence of gall stones—Chaney, at Mayo Clinic, in reviewing 69 cases of Banti's disease that had a splenectomy done found 8 with gall stones. Gall stones may not be as uncommon as we think.

(3) Urobilinogen in the urine was markedly increased. In cirrhosis of the liver the urinary urobilinogen is also increased.

This patient lives in the country and as she had recovered from her biliary colic was anxious to go home. She was therefore discharged before the investigation was completed. She will be returning in January to have this done. At that time the following investigation would be of value:

(1) Fecal urobilinogen.

(2) Plasma Proteins—which one expects will be down if she has much liver damage.

(3) X-ray of the oesophagus for the presence of varicosities.

(4) Punch liver biopsy.

I feel that a diagnosis of splenic anaemia should not be made until all the causes of anaemia, leucopenia and splenomegaly have been ruled out. This has been done in this case.

An effort was made to get a more complete record of the findings at the time of her cholecystotomy in 1940. The operative report showed no stones present, a thickened gall bladder and biliary duct, some thickening of the head of the pancreas and the presence of biliary cirrhosis.

In spite of the fact that the investigation in this case was not as complete as it might have been, I have made a dual diagnosis in this case:

1. Cholelithiasis.

2. Banti's Disease, i.e., Splenic Anaemia and Cirrhosis of the liver with the etiology of the cirrhosis being gall bladder disease.



1868 The pioneer Claude Adolphe Nativelle isolated the chief active principle of Digitalis Purpurea—Digitaline Nativelle.

1927 Sir James Mackenzie and James Orr described Digitaline Nativelle as "an elegant and effective preparation"—*Principles of Diagnosis and Treatment of Heart Affections*, Oxford. Med. Pubs. p. 219.

1945 Harry Gold found it the "preparation of choice for routine use"—*The Choice of a Digitalis Preparation*, Connecticut State Medical Journal, March 1945, Vol. IX, No. 3, p. 193.

Inclusion in N.N.R. from 1942 to the present day led to the Epoch of Digitoxin Therapy, with inclusion in U.S.P. XIII (1947).

Digitaline nativelle

The epoch-making product—pure crystalline glycoside from Digitalis Purpurea, not an adventitious mixture of glycosides—is still the yardstick of Digitalis Therapy. 1950 Schwartz stated "Digitaline Nativelle

will serve better in maintenance therapy"—*A Clinical investigation of the Digitoxins*, *The American Practitioner and Digest of Treatment*, Vol. 1, No. 1, George Macht also states "A striking finding was the greater pharmacological activity of Digitaline Nativelle"—*Special Pharmacology of Digitoxins* Arch. Int. Pharmacodyn., LXXI, No. 3, p. 345. 1951 marks Rougier Freres fiftieth year of devotion to medical advance through ethical specialties of therapeutic excellence.

1951

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WE TAKE PRIDE IN OUR PAST AND PLEDGE OUR FUTURE TO THE FINEST AND BEST

ORTHOPEDICS

Fractures of the Shafts of the Radius and Ulna*

E. S. James, M.D., F.R.C.S. (England and Canada)

A review of fractures of the forearm that attended the fracture clinic at the Winnipeg General Hospital and those treated in private practice during the last ten years reveal the following groups.

1. Colles' fracture (fractures about the wrist)	1163
2. Fractures of the head and neck of the radius	32
3. Fractures of the shaft of the radius	60
4. Fractures of the shaft of the ulna	34
5. Fractures of the olecranon and coronoid process	37
6. Fractures of the radius and ulna (greenstick)	67
7. Fractures of the radius and ulna (shafts) complete	87
8. Monteggia Fractures	10

1490

In this paper it is proposed to discuss only fractures of the shafts of the radius and ulna and to point out some of our experiences in the treatment of these cases.

Greenstick fractures were not a problem but a few words to the unwary may be in order. Firstly it was our experience that there is a great tendency to under correct the deformity, not to over correct it and that an increase in the angulation is liable to occur during the healing and especially when the swelling of the part subsides leaving a loose cast.

Our internes are warned to fully correct the deformity and the cast should be changed early. Re-check X-rays are taken before healing is solid. Even in two weeks firm union may be present. In a child minor deformities will disappear as growth occurs but these may be embarrassing to the surgeon for many months.

A good many years ago we were unfortunate enough to see several fractures of the radius and ulna unite in very bad position. These occurred where closed reduction was carried out. Union was delayed and the results were bad. Open reductions were then carried out where there was marked displacement. An accurate anatomical reduction was possible and the results were very encouraging. As time passed open reductions became the rule rather than the exception.

Since the ulna is the axis around which the forearm rotates, it is very necessary to have an accurate reduction of ulnar fractures, and of main-

taining them in correct alignment until union is solid. The rule is to first reduce and plate the ulna and next reduce and plate the radius. The earlier open reductions are performed the easier the operation will be. If operation is delayed several days reduction is often very difficult due to shortening of muscles, organization of blood clot, etc. Also displaced bony fragments often cause considerable damage to soft parts and this is minimized by early accurate reduction.

Stainless steel plates and screws are now used to retain the reduction. Several failures occurred where "too short plates were used." Six holed plates are advocated. It need hardly be mentioned that the screws should be put in parallel to each other and at right angles to the plate and that they must go through both cortices. It is our custom to take some bone chips from the shaft of the bone and lay them about the fracture site after the plate has been applied. Padded plaster casts are applied and these are changed to skin tight ones when the sutures are removed in ten to fourteen days time. Fractures of the shaft of radius and ulna often unite with a minimal amount of callous. Casts are retained until clinical and X-ray evidence of solid union is present.

Where non union has occurred bone grafting is necessary. Intramedullary grafts have been used but failures were too frequent to continue using them. Onlay grafts are very satisfactory and early union is usual. Cancellous bone chips from the crest of the ilium have been used in conjunction with onlay grafts or with fixation using a metal plate. It is felt that the cancellous bone insures earlier union. Cancellous grafts alone are liable to be absorbed if subjected to any strain.

There are ten cases of Monteggia fractures in this series. In them there is a forward or backward dislocation of the head of the radius with a fracture of the shaft of the ulna. Often the dislocation of the radius is not recognized and very bad results are obtained. Wherever one finds a fracture of the ulnar shaft with the radius intact be sure to include the elbow in the X-ray picture to note the position of the head of the radius.

Three of these eight cases were referred long after the fractured ulna had healed. In all the forward dislocation of the head of the radius caused a restriction of flexion at the elbow and in one a Volkmann's Ischaemic contraction had developed. It is probable that had the dislocation of the radius been reduced the circulation would not have been impaired. In two adults a removal of the head of the radius improved the elbow movements. Open reduction was carried out in five cases with a full return of function. When

*Presented at the Annual Meeting of the Manitoba Medical Association, October 4th, 1950.

the ulnar fracture is reduced completely the head of the radius will usually slip into place readily.

In three cases where there was a fracture of the shaft of radius a dislocation at the distal radio-ulnar joint was present. Here again the maintenance of an accurate reduction of the radius by internal fixation was necessary to restore the distal radio ulnar joint to its former state.

In several cases there was extensive damage to soft tissues as well as fractures of both bones of the forearm. Early operative treatment is emphasized to excise the devitalized tissue and bring about as complete a reduction as possible. An attempt must be made to maintain the length of the limb, but where bony substance has been lost, bone grafting must be deferred until the part is cleared of infecting organisms and the area has complete skin coverage.

any who despair of humanity, surely the thought of these thousands of men and women voluntarily giving their blood should raise hope in the most pessimistic.

Ways and means of recruiting new donors are constantly being studied by the Red Cross. Doctors can influence the relatives of patients. Perhaps my reader might in the coming year resolve to take a few minutes of his time now and then to support what I feel is the greatest single community service. After all, with infection to a high degree controllable by hygienic, antiseptic and antibiotic measures, blood and plasma become amongst the most important of all weapons against preventible loss of life.

Cecil Harris, B.Sc., M.D., M.R.C.P.
Provincial Medical Director.

Report and Comments on the Red Cross
Blood Bank, November, 1950

Name of Hospital	Elective and Urgent				Emergency	
	Issued	Used	Returned Unused	No. of Transfusions	Bottles Used	No. of Transfusions
Winnipeg General	730½	410½	320	239	49	45
St. Boniface	519	325	104	174	34	31
Misericordia	175½	103½	72	63	6	5
Grace	182	107	75	76	8	8
Deer Lodge	103	62	41	26	1	1
St. Boniface San.	2	1	1	1	—	—
Victoria	38	33	5	19	1	1
St. Joseph's	27	9	18	7	3	3
Concordia	41	26	15	16	5	5
Children's	24½	19½	5	21	4	4
King George	12	9	3	5	—	—
Shriners'	1	1	—	1	—	—
Selkirk General	10	5	5	4	17	17
Portage la Prairie	5	4	1	2	9	7
Brandon	3	—	3	—	42	40
Others	37½	15	15	15	23	14
Totals	1911	1138	773	669	202	181

Comments

I sometimes pause to consider the volunteer donors who attend the Red Cross Clinics at the rate of some two thousand a month. True, it is logical for the healthy among the community to support a community blood bank, but nevertheless I marvel at those who attend regularly whenever called and at those who attend for the first time. The latter come often with considerable apprehension, but nevertheless, they come. If there are

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Guest Speakers

Dr. Roy Farghuarson
Professor of Medicine, University of Toronto

Dr. Walter McKenzie
Professor of Surgery, University of Alberta
Doctor Farghuarson is planning to spend the week in Winnipeg and will be visiting Professor of Medicine.

Round Table Topics

Some of the round table topics on the program are:

1. Toxemias of Pregnancy.
2. Management of Menopause.
3. ACTH and Cortisone.
4. Management of Gall Bladder Disease.
5. Abdominal Surgery Emergencies in Children.

A complete program will be presented in the next issue of the Manitoba Medical Review.



ARTICLES

The Progress of the National Health Grants Program*

F. W. Jackson, M.D.

Mr. Chairman and Members of the Manitoba
Medical Association:

I am very happy to be here with you at your 1950 Annual Convention, and to have the privilege of speaking to you for a few moments on a subject of great interest to all of us, namely, The Progress of the National Health Grants Program.

This Program was evolved and brought into operation because it was believed that this should be the first step of a nation-wide drive directed towards the ultimate elimination, as far as possible, of ill-health. As a beginning to this, the provincial and local health departments must be strengthened to the greatest possible extent, and certain specific community health problems be more vigorously attacked.

The program makes provision this year for financial assistance to the Provinces of some Thirty-four Million Dollars in various fields of health, including hospital construction, research, tuberculosis control, venereal disease control, mental disease, cancer control, crippling conditions of children, professional training, and public health activities in general. I know that all of these fields are of deep interest to all practising medical men, but time will not permit me to discuss them in detail. I think I should, however, review briefly the progress of the plan to date, with reference to those parts of it of particular interest to medical practitioners.

One program that should be of interest to organized medicine is that in respect to professional training. Professional training of personnel is not only allowable under the Professional Training Grant, but that provision is made in all other grants to train people in the special fields of these grants. All types of health personnel can be trained—doctors, dentists, nurses, technicians, psychiatric social workers, engineers, veterinarians, sanitary inspectors, and others. The total trained or under training is 2,250 persons, of these 450 are doctors that have been or are being trained as public health officers, hospital administrators, radiologists, pathologists, psychiatrists, bacteriologists in tuberculosis, in pediatrics, cancer, obstetrics, and others in almost all spheres of medical practice.

All medical personnel working in the specialized types of medical care programs, such as mental disease, tuberculosis, cancer, crippled children,

etc., have had their work facilitated by the provision of the most modern types of equipment required for efficient services in these fields. Provincial laboratory diagnostic facilities have been materially improved. Thus, directly or indirectly, organized medicine, through its members, is benefiting from nearly every project which is approved by the Minister of National Health and Welfare.

While every effort is made to fight disease, some of our energies must be expended—not in the front line—but far back in the research laboratories where so often we must look for the weapons that will bring final victory. In the years immediately ahead there will undoubtedly be unparalleled progress in medical research.

To help accomplish this, 12 universities in Canada, 10 with faculties of medicine, are receiving very substantial financial assistance for research purposes out of the grant funds available this year.

It is not possible to go into detail for all the specific fields covered by the National Health Grants Program. However, one can indicate, by taking one of the grants and showing what has been done in it, what is or will be the pattern in the other fields covered.

In deference to your President, Dr. Scott, let us, for example, consider the field of tuberculosis control. Any good medical program consists of three main parts; namely, prevention of the disease, its treatment, and the rehabilitation of persons suffering from the disease. In the preventive field, increasing use is being made of B.C.G. In one Province alone nearly 50,000 persons were given this vaccine in 1949. The Provinces have not found it necessary to use grant funds for the stimulation and improvement of the preventive educational program. The Canadian Tuberculosis Association and the various provincial societies and boards have done and are doing an excellent job of public education.

To treat disease you must find it, so there is a case finding program. A great drive is being made at the present time in every Province of the Dominion to provide the utmost in facilities for the early detection of tuberculosis. This is being brought about by a tremendous increase in two main lines of approach; first, mass surveys of apparently well people; and second, admission x-ray plates of all persons entering hospital.

In the field of detection, particularly as it applies to mass surveys, a great deal of equipment has been provided in every Province from grant funds. This includes, not only stationary equipment for regular clinics and sanatoria, but also

*Presented at the Annual Meeting of the Manitoba Medical Association, Winnipeg, October 5th, 1950.

mobile units that go into the less well settled parts of the various Provinces and survey whole communities regularly.

In respect to the hospital admission program, this has been an almost completely new endeavour by tuberculosis authorities since the inception of the grants program. In every Province all the major hospitals now have miniature x-ray equipment to ensure that every patient will have a chest plate taken sometime during his stay in hospital, preferably, of course, at the time of his admission. This now is the most productive method of finding new cases of tuberculosis. In persons examined under the hospital admission program three times as many cases of tuberculosis are found per thousand examined as in mass surveys of the general population. The criterion, as to whether or not new equipment should be placed in the hospital, is that the hospital should have at least 1,200 admissions a year. Anything less than that, we think, makes it uneconomic to provide complete new equipment for the purpose of plating chests of patients admitted. However, in the smaller hospitals, arrangements can be made for the hospital to be paid the cost of chest plating their admissions by the use of their own x-ray equipment.

When it comes to the treatment of disease, a great deal of equipment and staff, both medical and nursing, have been provided in sanatoria across Canada. It is possible, for instance, to build a new sanatorium and equip and staff it from the funds available to the Province from their share of the tuberculosis control grant. In some Provinces, where there has been a shortage of beds and treatment facilities, this has been done.

We all know of the great benefit of the proper use of streptomycin in the treatment of tuberculosis. Since the beginning of the Program in August, 1948, very substantial amounts have been provided to all the Provinces for the purchase of this and allied drugs.

Whether or not the earlier detection of the disease and the improved treatment facilities are responsible, it is very gratifying and significant to note that the year 1949 showed a tremendous reduction in the tuberculosis death rates in Canada. The present Canadian death rate is now down to the exceptionally low figure of 30.4. Manitoba has done as well, if not better than most other Provinces, its total death rate being 28.9, and the death rate exclusive of Indians being only 15.1.

It is a very excellent thing, of course, to treat tuberculosis and have a satisfactory end result, but, in this particular disease, especially, the cure of the patient has to be considered in the light of his occupation at the time he took ill, and whether or not such occupation had a bearing on his break-

down. This immediately brings up the problem of rehabilitation.

When the Grants Program started there were only two Provinces in the Dominion which had what might be considered an organized rehabilitation program, and I am sure it must be a great satisfaction to the Manitoba Sanatorium Board to know that Manitoba took the lead in the Dominion of Canada in this particular phase of the whole tuberculosis problem. Now every Province in the Dominion is developing an organized rehabilitation program.

This program consists of many different phases. The object is to ensure, as far as this is possible, that each individual when his disease is arrested will be able to earn a living in some occupation that will reduce to the minimum the likelihood of recurrence of tuberculosis. Equipment of various descriptions has been purchased under the Tuberculosis Control Grant in every Province, to establish facilities for satisfactory rehabilitation. Personnel, both rehabilitation and placement officers have also been provided, as well as instructors in the various fields of training that may be put on under a provincial tuberculosis control program.

Another grant I should mention is the Mental Health Grant. Probably the most spectacular progress in providing extra services is being made under this grant. As an indication of this, we find that previous to the inauguration of the Health Grants Program there were only fourteen mental health clinics in Canada. Now there are nearly 60, and the ones that were established have been increased and improved by the addition of extra staff and equipment. In the treatment of the disease, every mental hospital in Canada has received assistance either by the way of new staff, occupational and recreational equipment, or the provision of extra beds for the treatment of patients.

We now find, also, a developing concept of the necessity of supervising discharged patients, and projects are starting to come in in order that facilities may be available to periodically visit and advise patients who have been discharged from mental institutions. This, in itself, should go a long way towards helping relieve the tremendous bed shortage in our institutions, by trying to ensure that a patient once discharged is able to remain at home and carry on satisfactorily.

Since the inception of the Grants Program in August, 1948, the Provinces will have received by April 1, 1951, a sum of not less than \$40,000,000 for the extension and improvement of health services.

It was suggested by some that this inauguration of the National Health Grants Program would

mean that at least some of the Provinces would reduce their own expenditures. This has not proved to be the case. During the first year of operation of the Program, every Province increased its own expenditures over the previous year. The total increase for all Provinces in Canada in the fiscal year 1948-49 was over 26 million dollars, a 30% increase.

In respect to the utilization of the Grant funds, Manitoba, this year, under most of the grants, is doing exceedingly well. One hundred per cent of the monies available under the Hospital Construction Grant has already been allotted, together with a quarter of a million dollars from funds unexpended during the past two years.

Under Venereal Disease Control, 100% of the grant has also been allotted, and in Professional Training nearly 90%.

There is one grant, however, in which the showing in Manitoba lags behind all the four Western Provinces. I refer to the Cancer Control Grant. It seems surprising to us at Ottawa that in any Province (and to myself, in particular that in the Province of Manitoba) only approximately 32% of the Federal funds available in this field this year have been requested.

We would like to see the whole of the grant for Cancer Control in all Provinces utilized. I am sure that Manitoba's share of the Grant, properly expended, would go a long way towards providing the type of service which we believe the people of this Province are entitled to. Non-utilization of the funds available for a worthwhile cancer program means that many people may go without the attention they need, with a resulting possibility of unnecessary wastage of our most precious resource—human life.

It is very gratifying to me to see by the Report of your Cancer Committee that negotiations between the Association and the Cancer Relief and Research Institute have been completed. This should insure that proper diagnosis, and treatment if necessary, of persons affected with cancer, will be available to everyone in the Province regardless of their ability to pay for such services.

All of us in Canada (and I include organized medicine, the thinking citizen, public health officials, and government) have the same objective, and this is to provide the best possible health care for every citizen of the Dominion. As the National Health Grants Program becomes stabilized we must begin to think of further advances to ultimately accomplish this. I am confident that in any extension of health services for the people of Canada no group would want to profit by exploiting another. There cannot be any form of intervention between the doctor and his patient which would prevent the patient from receiving

all the service he needs, where he needs it, and when he needs it. With the knowledge and experience which can commonly be pooled, we can devise a plan for a complete health program in every Province, which will ultimately provide the service we desire and which will be satisfactory to all.

There are many problems, of course, which have to be solved. One of the greatest of these is the present uneven distribution of medical services as between urban and rural areas.

"There is also the problem of the shortage of physicians. A careful study of the latest edition of the Survey of Physicians in Canada as at September, 1948, gives a far from encouraging picture. It shows that, although there had been a 2.4% increase in our population during the fifteen-month period under study, there had only been a .7% increase in the total number of physicians. In other words, our total population is increasing three times as fast as our medical personnel."

The provision of the required medical manpower and its distribution to make possible complete medical care for all our people is, in my opinion, the responsibility of, and can only be taken care of by, organized medicine through the various faculties of medicine of our Canadian universities.

In conclusion, Mr. Chairman, Ladies and Gentlemen, no Canadian, and certainly not one of us in this room, can take a negative attitude to this problem of improved medical care. In fact, the present international situation makes it imperative that each of us do everything he can to insure the highest possible standard of good health for all our people. The very survival of this democracy of ours may depend on this.

We know that the process of action and reaction between different groups seems to be inescapable in human affairs. However, I cannot see, when all parties concerned say they agree in the objective of the best possible health services for everyone, within the resources of the country, why there is any reason that the furtherance of a complete national health service should not be pursued. Indeed, there is every reason why it should. The professional groups, with their inside knowledge of what can and should be done, and government, with its desire to serve the people and implement adequate plans for such services, should be united, and if they are, they will be irresistible. The measure of divergence of viewpoint between medicine and the public, seems to me to be the measure of our failure as an intelligent society. Surely there can be no higher endeavour for Canadian medicine than to strike out boldly in new directions when the ultimate goal is better service to humanity.

The hope which is held out to the rheumatoid arthritic by the recent availability of Cortisone and A. C. T. H. is tremendous but until these substances have been fully assessed clinically and priced reasonably

"gold probably will continue to be important against arthritis for some time . . . it stopped the disease nearly 80 per cent of the time when used early"

CECIL, R. L. and ADAMS, C. A.,
Ann. of Int. Med., 33, July 1950, pp. 163-173

It would appear also that contemporary research points to the fact that gold salts will be beneficial in maintaining the relief obtained through hormone therapy

GOSSLINGS, J., HIJMANS, W. and LIMPT, P. M.,
Br. Med. Jour., Nov. 4, 1950, p. 1019

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MONTREAL

American College of Surgeons Annual Meeting

Ross Mitchell, M.D., Governor A.M.C.

The 36th annual clinical congress of the American College of Surgeons, including the 29th annual Hospital Standardization Conference, was held in Boston, October 23-27, with headquarters at the Hotel Statler. The term American must be interpreted in the widest sense, since not only does the College have members in both North and South America, but all over the globe. Registration was at the Mechanics Institute where also were the technical exhibits, color television and medical motion pictures. Panel discussions relating to the various specialties within surgery were held chiefly in the Copley Plaza Hotel hard by the famed Boston Public Library with its beautiful murals by Sargent and Abbey. Not least in interest were clinics held in twenty-five hospitals in the Boston area to which admission was by ticket. Tickets were obtainable at the Mechanics Institute on the basis of first come first served. It was stated that some 8,400 persons registered for the meeting.

So well-attended have these annual meetings become that the Board of Regents was forced to adopt a policy of holding them in future only in the three centres where adequate hotel accommodation can be had—New York, Chicago and San Francisco. It is in this latter city that the 1951 meeting will be held in place of Cleveland as originally planned. Regional two-day meetings such as that held in Winnipeg last April will be continued and will be made even more attractive.

The Boston meeting was huge, intense and colorful. No single auditorium could accommodate all who were present, but the general meetings were few. It was like a three-ring circus, save that there were many more rings. If one were wise, he would pick out the special panel discussions, the post-graduate discussions and the operative clinics which appealed to him and then at lunch or dinner meet men of like tastes. One could rub shoulders with the great, the near great and the coming great men of the surgical world as well as with the great throng of the rank and file.

The Presidential meeting in the ballroom of the Hotel Statler on the opening evening was outstanding. The platform was filled with officers, regents, and distinguished guests in their official robes. After the President, Frederick A. Collier, Ann Arbor, had given his address "For the Benefit of the Patients," the new officers were inaugurated in this order: First Vice-President, Warren H. Cole, Chicago; Second Vice-President, G. Gavin Miller, Montreal; President, Henry W. Cave, New York. The fifth Memorial Lecture in honor of Franklin H. Martin, moving spirit in the formation of the College, was given by Sir Geoffrey Jefferson, Pro-

fessor of Neurosurgery, University of Manchester. His title was "The Balance of Life and Death in Cerebral Lesions," and the lecture was worthy of the occasion.

Telecasts in color of operations performed at the Massachusetts General Hospital were shown each morning, Monday through Friday, and each afternoon except Friday. One observed was a radical abdominal hysterectomy by Joe V. Meigs, Clinical Professor of Gynecology, Harvard Medical School. The operative field could be seen clearly, the dissection was masterly and the surgeon's comments could be heard distinctly. In some respects the telecast was superior to the often blocked view of the observer in an operating theatre. The telecasts were so popular that it was difficult to obtain a seat.

Marvellous as television is, it cannot replace the meeting with surgical masters, seeing and hearing them in their own hospitals. No better hosts could be imagined than the Boston surgeons and gynecologists with their happy combination of exact knowledge, masterly skill, culture and friendliness. The mornings spent in the Free Hospital for Women will remain red letter memories after watching and listening to such men as George V. Smith, John Rock, Arthur Hertig, C. J. Duncan and W. J. Mulligan. Another memory is the visit to nearby Fearing Laboratory where the presiding genius is Olive W. Smith, Ph. D., wife of Dr. George V. Smith. One of the present research problems of this pair is the preparation and clinical application of protective pseudoglobulin (P Ps). Their work is based on the existence of a menstrual toxin responsible for some of the clinical properties of pre-eclamptic and eclamptic toxemias of pregnancy, and of protective factor capable of neutralizing this toxin both in animal experiments and in human cases.

Quite by chance I witnessed a demonstration by a senior resident in the Boston Lying-in Hospital to four internes of a new technic for collecting and storing unadulterated whole blood. This has been devised by Carl W. Walter, Department of Surgery, Harvard Medical School. The blood is collected into a collapsible bag of non-wettable, chemically inert, non-reactive plastic having a glossy inner surface. Clotting is prevented by drawing the blood through an ion exchange column to isolate the calcium. When the bag is full, the collecting tube is sealed by electricity and the bag is refrigerated. The blood is administered by inserting a perforating needle attached to the recipient set through a diaphragm in the delivery tube. The bag can be hung up for gravity flow or it can be put under the patient's buttock for pressure infusion.

At the Harvard Medical School Fletcher Eades spoke on "Prolonged Labor." Of patients with

labors of 30 hours or more ten per cent were sectioned, he said, under spinal anaesthesia with oxygen. Professor Maxwell Finland discussed Chemotherapy and Antibiotics. Aureomycin, chloromycetin and terramycin have a wider spectrum than penicillin and streptomycin. Johns Hopkins studies, he reported, showed aureomycin more effective than the other two. It is now available for intravenous administration. Dr. Mullane advocated the injections of sclerosing agents into varicose veins during pregnancy. With the patient standing he injects 0.5 to 2.00 cc at weekly intervals through a half-inch .25 needle. Injection is stopped when the patient completes 7 months of pregnancy. Dr. Romney discussed utero-placental blood flow.

One of the most interesting reports at an evening meeting was that of a method of giving fats intravenously. Dr. F. J. Stare, Professor of Nutrition at Harvard Medical School, pointed out that fat had a number of intrinsic advantages over either carbohydrates or protein as a parenteral source of calories. It provides 9 calories per gram rather than 4 for carbohydrates. It is not excreted by the kidney or bowel, and hence all fat calories given intravenously are available as energy. To date, he said, the fat emulsions had been used in more than 100 patients and two normal volunteers. From Boston University School of Medicine, Massachusetts General Hospital and Massachusetts Institute of Technology came a report of improved

equipment for measuring the electric potential of the stomach for use in the diagnosis of cancer of that organ.

Canada was well represented at this meeting. On the program were Professor Hans Selye of Montreal on "The concept of the General-Adaptation Syndrome as Applied to Surgical Problems" (with special emphasis on Cortisone and ACTH); J. C. Callaghan and W. G. Bigelow of Toronto, who described their electrical artificial pacemaker for standstill of the heart; A. D. Campbell, Newey Philpott, Wesley Bourne, G. Gavin Miller of Montreal, G. H. A. Clowes, John Hunter, R. W. Robertson of Toronto, and others.

The meeting was saddened by the news of the sudden illness of Dr. Austin B. Schinbein, of Vancouver, B.C., a member of the Board of Regents. Dr. Schinbein had a coronary attack which proved fatal a few days after his admission to hospital.

"All work and no play makes Jack a dull boy," so in company with Dr. J. O. Baker, of Edmonton I saw and heard John Gielgud and Pamela Brown give a notable performance of Christopher Fry's sparkling comedy "The Lady's Not for Burning," at the Shubert Theatre. Also seen was the N.H.L. scoreless game at Boston Garden between New York Rangers and the Boston Bruins.

A fellow passenger on T.C.A. to New York was Dr. H. W. Bottomley who was on his way to take a course in clinical allergy.

All in all it was a full and eventful week.

American College of Allergists Annual Meeting

The American College of Allergists will hold its seventh annual meeting at the Edgewater Beach Hotel, Chicago, Illinois, February 12, 13, 14, 1950. This year these will be section meetings: Psychosomatic aspects of allergic diseases, under the leadership of Harold Abramson, M.D., of New York; on Pediatrics, under Bret Ratner, M.D., of New York; on Allergies of the Nose and Throat, under George Shambaugh, M.D., of Chicago; on Allergic Diseases of the Skin, under Rudolph Baer, M.D., of New York City; and the Allergic Aspects of Rheumatism and Arthritis, under George Rockwell, M.D., of Cincinnati, as well as a general session of the College when hay fever, asthma and the newer drugs will be discussed under the leadership of John Mitchell, M.D., of Columbus, Ohio, the President of the College.

This year the College is trying for the first time the experiment of offering its post collegiate instructional course on the three days just preceding its annual conclave. This course has been arranged with the thought in mind that 10% or more of all the patients in a physician's practice have an allergic component in their complaint (The faculty consists of some 25 outstanding allergists). The course is therefore an extremely practical one designed for any physician who wants to learn the basic principles of diagnosis and treatment of allergic individuals and techniques that are useful in the management of these patients. A fee of \$35.00 will be charged for the three-day course lasting through February 9, 10, 11. For further information and registration write Fred Wittich, M.D., Secretary-Treasurer, American College of Allergists, 423 LaSalle Medical Building, Minneapolis, Minnesota.



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ANNIVERSARY YEAR

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Medico-Historical

J. C. Hossack, M.D., C.M. (Man.)

Medico-Historical

Much of the strength and weakness of Homoeopathy lies in the paltry fallacy, that every mother, and every clergyman, and "loose woman," as a wise friend calls the restless public old maid, may know when to administer aconite, arsenicum, and nux, to her child, his entire parish, or her "circle." Indeed here, as elsewhere, man's great difficulty is to strive to walk through life, and through thought and practice, in a straight line; to keep in medio—in that golden mean, which is our true centre of gravity, and which we lost in Eden. We all tend like children, or the blind, the old, or the tipsy, to walk to one side, or wildly from one side to the other: one extreme breeds its opposite. Hydropathy sees and speaks some truth, but it is as in its sleep, or with one eye shut, and one leg lame; its practice does good, much of its theory is sheer nonsense, and yet it is the theory that its masters and their constituents doat on.

If all that is good in the Water-Cure, and in Rubbing and in Homoeopathy, were winnowed from the false, the useless, and the

worse, what an important and permanent addition would be made to our operative knowledge! — to our powers as healers! and here it is, where I cannot help thinking that we have, as a profession, gone astray in our indiscriminate abuse of all these new practices and nostrums; they indicate, however, coarsely and stupidly, some want in us. There is in them all something good, and if we could draw to us, instead of driving away from us, those men whom we call, and in the main truly call, quacks—if we could absorb them with a difference, rejecting the ridiculous and mischievous much, and adopting and sanctioning the valuable little, we and the public would be all the better off. Why should not "the Faculty" have under their control and advice, and at their command, rubbers, and shampooers, and water men, and milk men, and grape men, and cudgelling men, as they have cuppers, and the like, instead of giving them the advantage of crying out "persecution," and quoting the martyrs of science from Galileo downwards.

Horae Subsecivae,
John Brown, M.D., LL.D., etc.

Meeting Winnipeg Medical Society

A special meeting of the Winnipeg Medical Society will be held in the Medical College on Tuesday evening, January 23rd, at 8.15 p.m.

The speaker on this occasion will be Dr. Johannes Clemmesen. The subject will be "The Epidemiology (Geographic Pathology) of Cancer."

Dr. Clemmesen is Registrar of the Danish Cancer Registry and Secretary of the Sub-Committee on Cancer of the Expert Committee on Health Statistics of the World Health Organization.

Dr. Clemmesen is on tour of various centres of the United States and Canada and will be in Winnipeg for several days.

Winnipeg Medical Society Benevolent Fund

In May, 1947, the Winnipeg Medical Society Benevolent Fund was organized. Its objects were:

"The Fund shall be used (a) to relieve distress or dire need of duly qualified medical practitioners, their wives, widows, children or direct dependents, (b) to further projects which are likely to conduce

to the further education of medical practitioners and indirectly of the general public."

To afford continuity of tenure in the executive, it has become customary to appoint the past president to a five-year term. This means that you always have men on the executive who have the confidence of the Medical Society, and who have a fair knowledge of the members of that body.

To date several members, their wives and children, have been helped over temporary difficulties, or have been helped to become self sustaining by this fund. In addition, it made a contribution to the Flood Relief, and has undertaken to perpetuate the Gordon Bell Memorial Lecture.

In the first four years of its being, times have been unusually prosperous and the need for assistance has been small. Now is the time to build up the fund to a substantial point, so that when harder times come, as well they may, there will be a foundation from which many kindly, necessary, and useful deeds may be financed.

At this time of year we would like you to think of this effort of goodwill, and send a generous donation to the secretary of the Winnipeg Medical Society Benevolent Fund, 604 Medical Arts Building.

EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor

The Opening Door

There is opening upon us a door which all of us would rather see remain closed. About three years ago the Provincial Government enacted legislation which recognized chiropractic and osteopathy as legitimate forms of practice. A year ago these practitioners obtained legislative permission to attend patients under the Workmen's Compensation Board. The Association had insufficient warning that the Medical Act was to be so amended so nothing could be done to block the passage of the amendment. This year the irregulars sought for, but did not obtain authority to be employed directly without the patient first getting permission from the Board. They have failed this time but, their motto being "it's dogged that does it," they will try and try again until, in all probability they will succeed.

The door having been pushed ajar, what is to prevent its further opening? If it is permissible to treat wards of the Compensation Board at home or in a place of business can authority to treat the same patients in hospital be logically denied? And if one government agency is willing to employ and pay such practitioners is it not probable that other government agencies will follow suit? Moreover if they are found acceptable in the rendering of one type of service might not the legislative authorities be coaxed to extend the scope of their activities until that scope is co-equal with our own, a state of affairs that exists even now in many of the United States?

In considering the situation there are some facts which we should bear in mind. First of all not one doctor in a hundred (if as many) has any knowledge of the theory or practice of any cult. It is the general opinion that irregulars are ignorant, dishonest people who batten on the credulity of people still more ignorant. This, I am sure, is a wrong appraisal. They are ignorant, we believe, of many things of which knowledge is necessary for the proper care of the sick. But most if not all of them are firmly persuaded that their methods are good—they believe in what they practice. Their theory may be absurd but it does not follow that their practice is without value. Elsewhere in these pages you will find what Dr. John Brown had to say about the irregulars of his time. He advised his colleagues to "reject the ridiculous and mischievous much and to adopt the valuable little."

That advice could with profit be followed today. It may be true that all those who claim that they have benefitted from chiropractic treatments are deluding themselves, but it is more

reasonable to believe that amongst them are people who have received benefit.

If this be so then our own practice is not complete. What can happen when irregular practice comes under the hand of scientific medicine is shown by the history of Orthopedics. Hugh Owen Thomas, his father, his grandfather and his great-grandfather were all "bone setters." Hugh Owen, however, took a medical degree and learned the strengths and weaknesses of his former practice. This knowledge he profited by and later imparted to his nephew, Sir Robert Jones, who is recognized as the father of orthopedic surgery. A study of chiropractic methods might reveal that they have a usefulness we have hitherto denied them. And if they are useful in the hands of unscientific manipulators they are likely to be still more valuable in the hands of men well trained in the basic sciences and the clinical arts.

The opening door poses a threat to us. We may find ourselves reduced in the eye of the Law to an equality with men whose course of study in scope, duration and intensity nowhere approaches our own. Irregular practices will not be shrugged off or laughed off or reasoned off. Only when we make use of the same methods which lead people elsewhere can we hope to put irregulars at a disadvantage. This does not mean that we should learn to become chiropractors but it does mean that what is good in manipulative practice should be learned and taught and practiced by ourselves. Then and only then can we hope to close the door now so ominously ajar.

New Features We Would Like to Present

For some time past I have had my editorial eye on three gentlemen. I regard them as valuable contributors In Posse. With luck I'll have them valuable contributors in esse and, in that event, we shall have two new features to grace our pages in the future.

One of these gentlemen is Dr. Speechly whose experience as King's Crowner goes back to the days when this was still a wildish and woolyish west. Dr. Speechly has already told me some of these experiences. One was about an unfortunate woman whose accoucheur, groping for her placenta, got his hand through a tear in her uterus (of the presence of which he was ignorant) and pulled out, and off, all her small bowel. The patient, gasping something about "butchers," naturally expired—as who wouldn't, with all their guts in a pail?

I was thinking of asking Dr. Fryer to give us some of his experiences also. If this were not a dignified and highly scientific journal I would be tempted to run a series under the caption of "Tales of a Gruesome Two-some." (Drs. F. and S. please forgive what you may regard as misplaced levity). But under the circumstances "Pages from a Coroner's Note Book" would be more appropriate.

At times, you know, it really must be fun (of a sort) to be a coroner and, in working about cases one could always touch up a leetle bit. For example the story might go like this: "The street to which I was called that evening was dingy and forlorn. It stood in a dismal, squalid depressing quarter of the city. It was a street deserted by all but a few houses and by every evidence of life. Even the trees, through which the wind whistled eerily, were bare and dead. The house itself was dilapidated and ruinous. I mounted the steps and rang the bell. There was no answer. This, however, was to be expected as most bells don't ring. But there was no answer either, to my loud and repeated knocks. Finally I tried the handle whereupon the door opened. I entered and no sooner had I done so than I slipped and would undoubtedly have fallen heavily upon the floor had it not been that a soft resilient object broke my fall. The hall was in almost total darkness but as I examined by my sense of touch the thing whereon I was seated I could make out contours which felt like arms and legs. It soon became obvious that I was sitting upon a body, an action quite in keeping (in legal parlance) with my official duties as King's Crouner, but one which so far during my whole term of office I was now performing literally for the first time.

Seeking to rise I stretched forth my hand and found it fall upon a globular, slippery object which quickly escaped from my grasp and rolled away. At the same time my hand seemed to become covered with a substance best described as "goeey," in that it had a peculiar stickiness.

As I have said the hall was in the deepest gloom so, in order to become orientated, I reached for my opthalmoscope (a very useful instrument for examining the fundi of dead people). With the faint illumination afforded by this feeble torch I surveyed the scene. As I suspected I was seated upon the stomach of a dead man and the gooey substance I quickly identified as blood. I next searched for the globular body on which my hand had for an instant rested. Again my original surmise was proven correct. It was a human head—a man's head, a head terribly in need of a shave, moreover a head which had obviously been hacked clumsily from the body, with a terrific effusion of the blood in the process whence came the gooey substance on which I had first slipped and then stained my hand. Removing myself from the corpse, whose lumbar lordosis I found un-

comfortably pronounced, I decided that this was a case for the police and accordingly made my way to the telephone—(Here, then, beginneth the Case of the Decapitated Corpse).

Or perhaps, the introduction might go thus: Although the month was July the heat within doors was much greater than one would expect. As I made my way along the walls I quickly discovered the reason—warm air was coming from the radiator. Heat on in July! That was definitely unusual. I therefore made my way to the basement which reeked with the smell of formaline, and opened the furnace door. There was evidence of recent combustion but probing of the fire box revealed nothing suspicious. Then I raked through the ashes and saw a smallish white object. Closer scrutiny suggested that this was not only a bone but a human bone to wit an os calcis. Whence came it? Obviously there was more here than met the eye. Thus beginneth the Case of the Calcined Os Calcis.

Written in this vein you can easily see how even a dull coroner's case could be made to throb with mortality and morbidity if such things were capable of throbbing. So I'm suggesting to coroners past, present and deputy that they enliven our pages with the records of some of their nice, clean crimes with which they have been connected.

The third gentleman I have in mind is personable Dr. Van. As the name of Dr. Van may not be familiar to some of our Australian or South African readers I repeat the following dialogue recently heard when two of his lady patients were discussing him.

First Lady: I've just seen Dr. Van (clasping her hands). Isn't he wonderful!

Second Lady: Hyperion's curls. The front of Jove himself!

First Lady: An eye, like Mars, to threaten and command!

Second Lady: A station like the herald Mercury new lighted on a heaven-kissing hill!

First Lady: A combination and a form indeed!

Both: What a man!

Now I would not have you think that this is mere fulsome flattery (which I loathe) or biased praise (which I abominate), and least of all is it meant to cause embarrassment to Dr. Van. It is set forth only that those who do not know Dr. Van may understand how well fitted he is for the job I have in mind for him.

The job, I may say, is to supply us with a monthly article entitled "Tales from the Big House," because Dr. Van is physician to the local jail.

Now, being so personable, and appealing as he does to the gentler sex he should find it easy to learn the story behind the story of why certain ladies (and gentlemen also) are unwilling guests

of His Majesty. I can imagine a dejected demi-mondaine presenting herself before him with a cut finger. Then the following conversation might follow.

Dr. Van: Well, Maisie, what have you got there? Maisie (indifferently): Just a cut finger.

Dr. Van (looking at the finger): Well a little ointment and a bit of bandage will soon fix that. (Then looking at Maisie) But I can see there's more wrong than that a cut finger! You have other wounds and scars! Is that not so?

Maisie: Yes doctor but how did you know? The scars are on my be— my abdomen and the other doctor said my insides were all tied up in knots.

Dr. Van: I didn't mean your old salpingitis, Maisie, I was thinking of scars upon your soul.

Maisie (suspiciously): You talk like a parson. I thought you were just a doctor.

Dr. Van: I'm not a parson Maisie and the soul I mean is not what parsons preach about. Maisie, did you ever hear about Socrates?

Maisie: Sounds like he might be a Greek. No, I never heard of him. What's his racket?

Dr. Van: Socrates has been dead for nearly twenty-four hundred years. He was a Greek philosopher. Once when a youth was brought to him with a headache he told the lad "Never give your head to be healed until you have first given your soul."

Maisie: But I haven't got a headache. I've got a cut finger.

Dr. Van: True, but you would not have cut your finger had you not been careless. And you would not have been careless unless your thoughts had been on some other matter. And that other matter concerns what doctors call the psyche which is the soul that Socrates had in mind. If

we knew what that matter was then we could find ways of making your life pleasant and happy.

Maisie: You ain't kiddin'?

Dr. Van: No it is true Maisie. Don't you ever read the Reader's Digest? All you have to do is tell me the sordid details, I beg your pardon, the details of your life and we can make you a new woman.

Maisie: What about the knots in my bowels?

Dr. Van: Don't you understand, Maisie, that having knots in your bowels is nothing to having knots in your brain? What I want to do is untie the knots in your brain.

Maisie: And that will fix up my bowels—and my finger?

Dr. Van: It will help a whole lot.

Maisie: I don't get it but what am I supposed to do?

Dr. Van: Just tell me the story of your life. Tell me, Maisie, when did you first the primrose path of dalliance tread? If you get what I mean.

Maisie: I'm not sure that I do. You mean when did I . . . yah I get ya. I was only a kid at that time. I guess I worn't even 15 when . . . If Dr. Van (or anyone else) thinks I'm going to finish for him the Tale of Maisie the Magdalene he's grossly mistaken. I've broken the ice for him: it's up to him to do the rest.

Now, if I can persuade the gentlemen I have mentioned to furnish us regularly with material, you can see how our Review would be in even greater demand than it is. It would seem that nothing is more popular than a good juicy crime or an excursion (via print) into the underworld. After all "a little murder now and then" as the poet says, "Is relished by the wisest men." I'll do my best to get this for you and if I don't succeed don't blame me.





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SOCIAL NEWS

Reported by K. Borthwick-Leslie, M.D.

That was a most impressive picture of our Air Force M.O.'s taken while attending a Refresher Course at the School of Aviation Medicine, Toronto. Group Capt. G. I. Adamson, Major J. L. Johnston, Rivers, Man.; Squadron Leader J. C. Pincock, F/Lt. J. L. Becksted and F/Lt. H. E. Bowles were our Manitoba men taking the course, the first of its kind by the way, since the last war.

Our Navy is in the limelight also with Lieut.-Commander Gordon Fahrni being promoted to the rank of Surgeon Commander. Congratulations. Army!! where art thou?

Welcome to the Medical Arts to George H. Levian, F.R.C.S. (Eng.), D.O.M.S., who is to be in charge of the new Department of Ophthalmology in the Manitoba Clinic.

Of interest to the many friends in Manitoba, I had a card from Dr. Anna Nicholson, Saskatoon, and they are migrating shortly to the Barbados for two years. Dr. Anna to swim in the sea and do Anaesthesiology.

Dr. and Mrs. Govan and small daughter spent the festive season with the doctor's parents in Winnipeg. Dr. Govan will return to Montreal to complete his P.G. studies, then they plan to take up residence in Vancouver.

Dr. Donald Magee, who is studying in Boston, Mass., was another Christmas visitor in Winnipeg, spending the holiday with his mother, Mrs. R. C. E. Magee.

Dean Hillsman, looking healthy and handsome, also spent his Christmas vacation with his parents, Dr. and Mrs. John Hillsman.

Brief news from Harold and Pat Blondal, London, Eng. They are in their glory. Harold, deep in research in the Cancer Research Hospital, Pat in exploring the wonders of England, both hoping to survive no fuel, no meat, and too much tea.

Dr. and Mrs. C. R. Gilmour are holidaying in Charleston, South Carolina. A very smart idea, with Old Man Winter doing his stuff so efficiently here.

Dr. Sydney Calimentsky and his bride, formerly Nessa Levinson, Vancouver, will reside in the Fredericton Apartments, Winnipeg.

Long Island, New York City, was the scene Dec. 30 of the marriage of Dr. Ethel Bookhalter to Dr. Herman Steinberg. Mrs. Louis Levine, sister of the bride, was Matron of Honor and Mr. Paul Bookhalter, father of the bride, attended the ceremony.

In Honolulu, Shirley MacCharles, younger daughter of Dr. and Mrs. M. R. MacCharles, became the bride of Dudley Bruce Mobberley, son of Mr. and Mrs. J. H. Mobberley, Winnipeg. Mr. and Mrs. Mobberley, Jr., will make their home on Aloha Drive, Honolulu.

On Dec. 30, 1950, Audrey M. Smith became the bride of Kenneth R. McGavin, son of Mrs. McGavin and the late Dr. McGavin. The young couple will reside in Winnipeg.

Remember how you felt and looked when you were given your first electric train or "sleeping doll?" That is the expression of Dr. J. Hoogstraten when he was presented, by the Junior St. Agnes Guild, with that marvelous Zeis-Winkel Binocular Microscope and Kod-Slide Table Viewer for the Research Laboratory at the Children's Hospital.

Congratulations to Dr. Francis Mathewson on his appointment as Medical Director for the Great West Life Assurance Co. He succeeds our old friend, Dr. B. H. Olson, who is retiring. Dr. Mathewson will remain on the teaching staff of the Faculty of Medicine.

Welcome to the West and Prairie Command to Lieut.-Col. Carl G. Wood, O.B.E., R.C.A.M.C., as command Medical Officer. He takes over from Lieut.-Col. Morgan-Smith, who has been selected to attend the Australian Staff College, reporting in the near future.

Joan Jennifer Stevenson, six months old daughter of Dr. and Mrs. John Stevenson, Vancouver, formerly of Winnipeg, was christened in Vancouver last week.

It is with regret that I have to pass on the belated news of the death, following an automobile accident, of Dr. Ivan Sneath (Bud) Sept. 25, 1950. May we extend our sympathy to his many friends and his family.

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... on bronchial asthma

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ASSOCIATION PAGE

Reported by M. T. Macfarland, M.D.

"Ring out, wild bells, to the wild sky,
The flying cloud, the frosty light:
The year is dying in the night;
Ring out, wild bells, and let him die.

Ring out the grief that saps the mind,
For those that here we see no more;
Ring out the feud of rich and poor,
Ring in redress to all mankind.

Ring out the slowly dying cause,
And ancient forms of party strife;
Ring in the nobler modes of life,
With sweeter manners, purer laws.

Ring out false pride in place and blood,
The civic slander and the spite;
Ring in the love of truth and right
Ring in the common love of good.

Ring out old shapes of foul disease;
Ring out the narrowing lust of gold;
Ring out the thousand wars of old,
Ring in the thousand years of peace."

(Tennyson)

"Once to every man and nation
Comes the moment to decide,
In the strife of truth with falsehood,
For the good or evil side:

New occasions teach new duties;
Time makes ancient good uncouth;
They must upward still and onward
Who would keep abreast of truth.

Though the cause of evil prosper,
Yet 'tis truth alone is strong;
Though her portion be the scaffold,
And upon the throne be wrong.

Yet that scaffold sways the future,
And, behind the dim unknown,
Standeth God within the shadows,
Keeping watch above his own."

(Lowell)

Plans Set For Canada's First Medical Color Television Program

Montreal—Color television is coming to Canada. Officials of the Canadian Medical Association yesterday concluded here final arrangements for bringing to Montreal next June the nation's first medical color television program.

Meeting with C.M.A. officers in planning the program were the directors and sponsors of the colorcasts, Smith, Kline & French, Inter-American Corp., the Montreal pharmaceutical manufacturers who are pioneering the medium in Canada as a service to the medical profession.

The President of the Canadian Medical Association, Dr. Norman H. Gosse of Halifax, said:

"I welcome the opportunity to comment on the plan for having color television at our annual meeting. This is the first time color television has been used in Canada to teach medicine, and we are greatly indebted to Smith, Kline & French for arranging it."

"We look upon color television as a valuable new method in medical education," he stated. "It has been added to our program not as an exhibition, although it is extremely dramatic, but because of its teaching value. I am delighted to announce that plans for its introduction at our meeting are

well under way, and I look forward to what I feel will be a significant contribution to teaching medicine in Canada."

Under discussion yesterday was the selection of a transmitting point for the program, which is to be presented during the C.M.A.'s annual convention. An offer by the Royal Victoria Hospital was accepted and from operating rooms there, colorcasts of the latest medical and surgical techniques will be beamed directly to special receivers set up in the Mount Royal Hotel, where the C.M.A. convention will take place.

Color television, unknown to the general public in both Canada and the U.S., has been used at medical meetings in the States for the last year and a half to teach medical procedures. Smith, Kline & French's U.S. affiliate, S.K.&F. Laboratories of Philadelphia, have pioneered these programs.

Dr. Campbell Gardner, Chief of Service-Surgery at Queen Mary Veterans Hospital in Montreal and Chairman of the C.M.A.'s Television Committee, explained why color television will be such an attraction at the C.M.A. meeting.

He pointed out that personal observation is one of the most important ways of learning medicine and surgery. "However," he said, "modern surgery demands a team of specialists instead of

one doctor and a nurse or two. This team surrounds the operating table and blocks the view for observers with the result that the practice is falling into disuse. What's more, operating room amphitheatres do not, as a rule, accommodate many observers at a time."

"Color TV," Dr. Gardner continued, "overcomes all these difficulties. The camera, poised but a few feet over the patient, doesn't in any way interfere with the team. At the same time, it sees just what the surgeon sees and instantly transmits this information to the audience, unlimited in size except by the number of receivers tuned in. The commentary of the surgeon as he performs his operation is picked up by a tiny mike hidden in his mask and is sent to the receivers along with the pictures. The effect is that you are standing right beside the operating table."

Dr. Gardner, who has seen several of the S.K.&F. colorcasts in the States, and who has sparked the drive to bring the medium to the C.M.A. convention, said that color makes television an effective medical teaching aid. "Color is essential," he commented, "because it gives a sense of third dimension, because it permits recog-

nition of tissue and tissue changes, and because it permits anatomical orientation. Without color the most experienced surgeon would have difficulty in identifying an operation on a TV screen."

"The color equipment which S.K.&F. own, and operates was designed and built for them for this teaching purpose by the Engineering Research and Development Laboratories of the Columbia Broadcasting System. This equipment uses a spinning disk in the camera to break down natural colors into their components—red, blue and green. Another disk in the receiver, spinning in synchronization with the camera disk, reverses the process so that a full color picture is seen by the eye.

Until recently, it was the only equipment of its kind in active use. It is still the only color television unit exclusively designed and used to teach medicine and surgery in North America although medical institutions in both Canada and the U.S. are actively planning to install color TV as a permanent part of their teaching equipment. These plans are largely based on the results achieved from such programs as the C.M.A. will present for its members next June.

Medical Registration and the Closed Shop

Statement by Dr. M. T. Macfarland, Registrar of the College of Physicians and Surgeons of Manitoba, at the meeting of the Winnipeg Medical Society, December 15th, 1950.

Editorial comments on the Alberta Government proposal to take over licensing of the professions have brought the subject of medical licensure into the limelight.

The purpose of medical licensure is to enable persons requiring medical aid to distinguish qualified from unqualified practitioners.

Far from being a closed shop, the College of Physicians and Surgeons of Manitoba is bound, under Provincial Statutes, to issue a licence to any graduate of a Canadian medical school who presents his basic sciences certificate, his qualifying Medical Council of Canada licence, his certificate of a year's internship, and \$100.00. It would be possible for the whole graduating class of the University of Montreal to register here in a body. American graduates of recognized schools may register under the same conditions. Any British subject of an approved medical school, enrolled on the British Medical Register, may register in Manitoba without examination, on presenting his credentials including basic sciences and internship certificates. In fact 44 doctors have registered here by reciprocity with the General Medical Council of Great Britain in the past three years.

Refugee physicians are subject to the same conditions as graduates of Canadian schools, with the additional safeguard that an Enabling Certificate to write the examinations of the Medical Council of Canada is only granted if the applicant's documents, medical school background and linguistic ability in English or French is satisfactory. Otherwise a year's internship locally is required. So far five such individuals have been granted Enabling Certificates out of a total of twelve whose applications have been considered and will be registered upon passing the examinations of the Medical Council of Canada.

That sympathetic consideration is given to refugees is evidenced by this letter from Mr. Hector Allard, Chief of Mission (Canada), International Refugee Organization, Hull, Quebec:

"It was indeed very kind of you to receive me on Tuesday, August 22nd, to discuss points of mutual interest with regard to former Displaced Persons who have arrived in Canada and who claim to be members of the medical profession."

"After discussing this matter with you, I feel sure that DPs are being given every possible consideration by the Manitoba College of Physicians and Surgeons, and this is due in great part to your keen interest in this problem."

Much has been printed on the scarcity of doctors in Manitoba. In 1949 there were 977 of population per active physician in the whole of Canada. In 1950 in Manitoba the equivalent

figure was 1,025 of population per active physician, i.e. 775 doctors for 795,000 estimated people. Actually there are 1,535 names of living doctors on the Manitoba Register. The difference between 1,535 and 775 represents doctors who have left for greener fields or are doing postgraduate work abroad.

The largest number of localities named by the Department of Health and Public Welfare of Manitoba as needing doctors was 26 in 1948. A critical survey of these localities showed that only half of these towns could actually support a doctor. As an example some months ago a Manitoba village advertised for a doctor. This locality was mentioned to 43 doctors enquiring at the Manitoba Medical Association office. The town is still without a doctor, for obvious reasons.

Cancer Diagnostic Service

The Manitoba Cancer Institute and the Manitoba Medical Association jointly announce the institution of a Cancer Diagnostic Service, specifically for the residents of rural Manitoba in straitened financial circumstances, who are suspected by their doctor of having cancer.

These co-operating organizations have recognized that there exist certain geographic and economic conditions peculiar to the rural areas of Manitoba, which result in delayed cancer diagnosis for that group of the rural population who, for financial reasons, are not in a position to employ the services of private medical consultants. The patient involved will first see his own physician who will conduct a preliminary examination. If the result indicates the necessity for an extensive investigation, and if in the opinion of the physician, the over-all costs involved would be beyond the means of the patient, the patient may be referred to the new Diagnostic Service upon confirmation of his economic status by an official of his municipality.

The inauguration of the Cancer Diagnostic Service for this particular group assures that all groups in the province, both urban and rural, have immediate access to specialized diagnostic services: the private patients in the province through their private physicians, the indigents in the Greater Winnipeg area through the Out Patient Departments and the public wards of the hospitals, and the economically distressed in the rural areas through the new Cancer Diagnostic Service. In the beginning these services will be available at the Winnipeg General Hospital and the St. Boniface Hospital—later the services may be provided at other hospitals.

In addition to diagnostic services, the new clinics will also provide increased facilities to the University of Manitoba for instruction in cancer. The University will participate by the appointment of Teaching Fellows to the clinics, thus making them an integral part of its medical educational program.

The operation of the service will involve a considerable expenditure through the hospitals concerned—expenditures dealing with the provision of x-ray and laboratory diagnostic procedures. These costs, together with the costs of hospitalization, will be met by the Cancer Institute through funds provided by Federal, Provincial and Municipal bodies. The medical services on the other hand, will be provided without charge or recompense. All the doctors participating in the work of these clinics do so without remuneration.

Experience over past years has established, beyond question, the importance of early diagnosis in reducing cancer mortality. It is the opinion of the Cancer Institute and the Medical Association that the Service now announced will become a significant factor in increasing the life expectancy of cancer patients in this province.

The service becomes effective December 1st, 1950, and reference forms, as per sample attached, may be obtained through the Cancer Relief and Research Institute.

Date

To the Registrar,

Cancer Diagnostic Service,

..... Hospital.

RE:

I have examined this patient and find symptoms suggestive of malignancy, which require further investigation.

In my opinion his financial status would prohibit him from paying for this service, and I am accordingly recommending him for examination in the Cancer Service provided by the Manitoba Cancer Institute and by members of the Manitoba Medical Association.

..... M.D.

I concur in the above statement on financial status.

..... (Municipal Official)

(This form is to be presented by the patient upon arrival at the Cancer Diagnostic Service).

National Disaster Services Institute

The second Institute was organized by the Canadian Red Cross Society and held for two full days, November 23rd and 24th, 1950, at the Royal Alexandra Hotel. The Executive Secretary attended as an observer, for the Canadian Medical Association, the Manitoba Division, and the Winnipeg Medical Society.

The letter of invitation to each of the federal, provincial, and local medical bodies was similar in form, and indicated "It is generally recognized that the pattern of co-operation between government and voluntary agencies established at the time (Manitoba Flood) will be of inestimable value in future disaster and civil defence planning."

In the absence of Major-General Churchill Mann, the gathering was presided over by Dr. W. S. Stanbury, National Commissioner, Canadian Red Cross Society. Mr. J. A. MacAuley, K.C., brought greetings to the delegates from the various provinces. Mr. R. G. B. Dickson, President, Manitoba Division, Canadian Red Cross Society, outlined the role of the Red Cross in the 1950 Manitoba Flood.

Mr. Dickson explained that, due to the late planning of the Medical and Nursing Division, the organization agreed upon was not entirely Red Cross, but advantage was taken by groups organized under the Command Medical Officer of facilities provided.

Mr. W. D. Hurst, City Engineer, Winnipeg, outlined measures already in effect, or to be taken in the future, to prevent or minimize damages from flood. He pleaded for centralized control and close working agreements between volunteer organizations to avoid duplication of effort and competition.

Mr. Colin Herrle, American Red Cross, discussed Governmental and Red Cross responsibilities as applied more to situation in the United States of America. He indicated that Canada may expect an increased number of disasters from floods, blizzards, explosions, forest fires, train, bus, aeroplane accidents, etc., as further development and expansion is brought about. He stressed the need for understanding responsibilities, and for mutual co-operation. A manual (U.S.) indicates division of responsibility.

Representatives of the governmental agencies who spoke were officers of the Air Force and Navy. Inspector Lockwood, R.C.M.P., and Chief Constable McIver, head of the City of Winnipeg police force, outlined functions of their organizations during the flood. The noon luncheon speaker was Brig. R. E. A. Morton, who paid a glowing compliment to the medical profession which carried out not only an evacuation scheme, but also returned patients to Winnipeg.

During the afternoon session, Brig. R. S. Malone discussed operation "Blackboy" which would have

been put into operation when the water reached the 32' 5" mark. Mr. Frank Carpenter, Chairman, Disaster Planning Committee, outlined the role assumed by the Red Cross.

Col. F. W. G. Miles discussed the problem of registration and welfare inquiries, and was joined by Mrs. I. Handy, American Red Cross Society. The problem posed is "who should register people in a disaster?" Tribute was paid to commercial communications systems, and the suggestion made that, while the latter are available, "ham" radio sets should not be used.

Mr. J. W. Percival (Report No. 8) gave an account of arrangements for the supply of food while Mr. N. Smith, Mrs. C. Rhodes Smith and Mrs. J. A. Argue detailed the clothing arrangements. It was agreed that a plentiful supply of blankets is a "Must" in any disaster, also that conditioning of clothing should be carried out at the point of collection rather than at the point of distribution.

Report No. 3 dealt with the provision of transportation facilities, and Miss Bayer outlined some features of volunteer recruitment. At the Friday morning session, Messrs. J. Ross Murray and W. S. M. Lang gave the report (No. 2) of the Shelter and Evacuation Committee. Mr. N. Des Brisay spoke on the control of train movements and Mr. Wm. Courage on Emergency Shelter. Mr. W. Macdonald presented the Report (No. 1) on Field Supervision of Evacuees.

Medical Account (Report No. 6) was presented by Doctor Gordon S. Fahrni, Lt.-Col. G. L. Morgan Smith and Miss Lillian Pettigrew. The report was the most voluminous presented at the Institute and contained much detail. "The experience of the Manitoba Flood demonstrated once again the effect of an emergency in stimulating all concerned to exert their best efforts to meet the task at hand. Request or an order brought an immediate response without question, from all services and civilian personnel showed no line of cleavage. The doctors were spontaneous in their response, the nurses magnificent in their co-operation, and the lay aid were plentiful and efficient." Most disasters involve a great deal more medical, surgical and hospital care than was the case during the 1950 flood.

In speaking on Publicity (Report No. 4), Mr. J. N. Kelly said it was "doing the right thing at the right time and getting credit for it" but it was perhaps most fortunate that the majority of those who were "doing" did so without any thought of publicity. The Communication problem was discussed by Mr. E. Elsey. Purchasing (Report No. 5) was described as having "the right things in the right quantity at the right time and place." Mr. Sill outlined the Accounting system which was set up. Welfare Services (Report No. 7) were provided under the direction of Miss Bessie Touzel.

The whole tone of the Institute was to stress the necessity of an overall plan outlined on the federal level, setting forth the authority and

Obituary

Dr. Bruce Hill

Dr. Bruce Hill died at his home in St. James on Dec. 29, aged 73. Born at Morden, Man., he graduated from Manitoba College in 1901. After postgraduate work in Chicago and New York, he practised for six years at Swan River and then in Winnipeg. He is survived by his wife.

Clinical Luncheons

Time Table for Clinical Luncheons held during the Season in Greater Winnipeg Hospitals. The days in each month on which the luncheons are held are listed herewith. Visiting doctors are welcome.

- 1st Monday—Deer Lodge Hospital.
1st Tuesday—Municipal Hospital.
1st Thursday—Winnipeg General Hospital.
1st Friday—Children's Hospital.
2nd Tuesday—Misericordia Hospital.
2nd Thursday—St. Boniface Hospital.
2nd Friday—Victoria Hospital
3rd Tuesday—Grace Hospital.
3rd Thursday—Winnipeg General Hospital.
4th Tuesday—St. Joseph's Hospital.
4th Thursday—St. Boniface Hospital.

Attention Salaried Physicians

All physicians who are on salary contract, plus expenses, should ensure that the employer reports salary only to the Income Tax Department, otherwise they may find themselves liable for tax on expense items. Municipal physicians should have a special interest in this matter.

Office For Rent

Doctor to share small office building with well established dentist in large residential-business section of Winnipeg. Previous doctor left to specialize. No goodwill. Reasonable rental. Apply Box 101, Manitoba Medical Review.

responsibility on which action should be taken. With such a master outline the provincial and municipal authorities will be enabled to dovetail the local organization which will be the one charged with the ultimate carrying out of the plan.

The medical profession is already committed on the level of the Defence Medical and Dental Advisory Board, and it is from that direction that suggestions should come for planning on the provincial and municipal level. No time should be lost in clarifying this situation.

General Practice Position Vacant

Doctor to engage in General Practice with a Clinic Group in a moderate sized city in North-western Ontario. Must be licensed to practice in Ontario and have a minimum of one year's rotation service as an interne, preferably two years. Position to be filled as soon as possible on a permanent basis. Monthly salary with increases. Car allowance. Suitable candidate will ultimately be considered for admission to partnership. Direct reply giving all particulars regarding age, training, qualifications, experience, marital status, salary expected, etc., to Box 311, Manitoba Medical Review.

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The progress of the patient is, therefore, unhindered by serious side reactions.
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COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

Council Meeting

October 18, 1950.

The Sixty-fifth Annual Meeting of the Council of the College of Physicians and Surgeons of Manitoba was held Wednesday, October 18th, 1950, at 6 o'clock p.m., at the Medical College, Winnipeg.

The President, Dr. Edward Johnson, called the meeting to order.

Roll Call

The following members were present:

Doctors Edward Johnson, President; I. Pearlman, Vice-President; T. H. Williams, Treasurer; A. T. Macfarland, Registrar; B. D. Best, W. J. Boyd, C. E. Corrigan, B. Dyma, H. Guyot, Wm. Malyska, A. L. Paine, J. S. Poole, T. W. Shaw, C. B. Stewart, C. H. A. Walton and C. W. Wiebe.

Dr. Johnson introduced Doctors Wm. Malyska and A. L. Paine, in attendance for the first time, to members of the Council.

Dr. Macfarland presented the following list of names of members of the College deceased during the year:

Doctors Andrew Allan Alford, Oakville; Frank Woodside Boyd, Winnipeg; Edward Ainslee Braithwaite, Edmonton, Alberta; John Brown, Vancouver, B.C.; Jeremiah Simpson Clark, Regina, Saskatchewan; Clifford Bruce Colquette, Brantford, Ontario; James Scott Conklin, Vancouver, B.C.; Emile Desrochers, Montreal, P.Q.; Margaret Ellen Douglass, Winnipeg; William Vincent Edwards, Roland; McGillivray Stuart Fraser, Winnipeg; William John Gunne, Kenora, Ontario; Omer Grenville Hague, Winnipeg; Edward Alfred Jones, Winnipeg; Arthur Larose, The Pas; John Angus MacDougall, Winnipeg; James Currie McMillan, Winnipeg; Robert Sidney McMunn, Winnipeg; Edward Browne O'Reilly, Hamilton, Ontario; Wellington LeRoy Pedlow, Caulfield, B.C.; Egerton Lewellyn Pope, Edmonton, Alberta; Albert St. Clair Rumball, Regina, Saskatchewan; Ivan Wallwin Sneath, Regina, Saskatchewan; Alexander James Swan, Winnipeg; Benjamin Aaron Victor, Winnipeg; Charles Harvey Vrooman, Vancouver, B.C.; Fred Carlyle Wilson, Melita.

A period of silence was observed in memory of these physicians.

2. Reading of Minutes and Their Approval

Dr. Johnson stated that the minutes of the May Council Meeting had been circulated to the members of Council, and also published in the Manitoba Medical Review.

Motion: "THAT the minutes of the May Council Meeting be taken as read." Carried.

3. Reports of Officers and Their Consideration Registrar's Report

The Registrar presented the following report:

Once again it is my pleasure to report to Council some highlights of an exceptionally busy year in which hearty co-operation has been extended by members of Council.

Meetings

During the year there have been:

- 1 special meeting of Council on May 23rd.
- 8 meetings of Registration Committee, 5 prior to and 3 subsequent to the May meeting of Council.
- 3 meetings of Executive Committee, 2 prior to and 1 subsequent to the May meeting of Council.
- 1 meeting of Legislative Committee, prior to the May meeting of Council.
- 2 meetings of Discipline Committee, 1 prior to and 1 subsequent to the May meeting of Council.

Mimeographed minutes of all meetings have been distributed to each member and individual items may be discussed as the report of each Committee is presented.

Student Registration

Most provincial licencing bodies have provisions whereby students resident in the Province are enrolled at the commencement of the medical course. 78 applications were approved during the year, at the nominal charge of \$1.00, and the sum was added to our treasury. Acceptance of students registered at the University of Ottawa will mean that Enabling Certificates will probably be granted to these students on graduation. It has often occurred to me that some local contact, in addition to this first one, which is on a financial basis, might well be made by this College with medical students prior to the final or graduating year when they return for payment of an additional sum for the Enabling Certificate to write the examinations of the Medical Council of Canada.

Enabling Certificates

37 were granted and 4 deferred from 91 applications, in which all the required documents were made available to the Registration Committee. In addition to graduates from the University of Manitoba, applications were from graduates of other schools in Canada (2), United States (10), Iceland (1), Europe (4), 3 were deferred; and Asia (14), 1 was deferred. A charge of \$5.00 is made for each Certificate, accounting for \$435.00 addition to the finances.

Certificate of Licence

Of 8 applications for temporary licences, 2 were graduates of the University of Manitoba, 1 from another Canadian university, and 5 from the United

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Kingdom. 5 licences were requested for Public Health Officers, Sanatorium Board or Provincial institution employees, 2 for hospital internes, and 1 for a Red Cross Medical Officer. 2 Certificates of Licence were replaced by full registration and 4 Certificates were cancelled. 4 of the holders remain in rural Manitoba, 3 in Winnipeg, while 1 returned to complete his military service in the United Kingdom. Revenue from this source was \$75.00—Six \$10.00 and two \$5.00 Certificates, while the holder of one \$5.00 Certificate contributed the similar sum when his category was changed.

Registration

At the time of application:

- 43 were graduates of University of Manitoba,
- 16 were graduates of other Canadian universities,
- 2 were graduates of the U.S.A.,
- 13 were from the United Kingdom, and
- 9 were from Asia,

83 total.

They indicated their intentions as follows:

- 35 wished to practise in Manitoba,
- 24 wished to accept Institutional Industrial or Public Health appointments in Manitoba,
- 14 wished to do Post Graduate work in Manitoba, Canada, or the United Kingdom,
- 10 wished to obtain reciprocal registration with the United Kingdom to enable them to practise within the Commonwealth areas.

At the end of the year, that is, Sept. 30, 1950:

- 64 remained in Manitoba,
- 3 had gone to another province,
- 1 to the United States of America,
- 6 to the United Kingdom, and
- 9 to another country.

The figure of 64 registrants remaining in Manitoba is almost exactly that of the number of graduates from the University of Manitoba in the present year. It is interesting to recall the remarks of the Minister of Health and Public Welfare at the last session of the Legislature that, if one graduating class remained in Manitoba, the need for doctors would be adequately met.

Income from 83 registrations was as follows:

72 @ \$100.00	\$7,200.00
5 @ 95.00	475.00
6 @ 90.00	540.00

\$8,215.00

This figure differs slightly from that of the Auditor, in that the additional \$5.00 collected on Certificate of Licence No. 27 was credited in our office under the heading of Temporary Licences.

Annual Fees

As a result of the increased fee, the amount of \$3,339.00 was collected as compared with \$1,328.00

in 1949. As agreed by Council last year, Life Membership was granted under the resolution of October, 1933, to the following members, who are relieved from the payment of fees:

Doctors George Perry Armstrong, Portage la Prairie; Percy George Bell, Winnipeg; Frederick Valentine Bird, Boissevain; Sveinn Ericksson Bjornson, Oak River; William Creighton, Winnipeg; Richard Roy, Dunrea.

Arrears in Fees

20 members are in arrears of their 1950 annual fees, only one of these being in arrears of the 1949 fee as well.

Other income totalling \$433.87 is made up as follows:

G.M.C. Certificates	\$ 85.00
Mailing lists of registered physicians	227.00
Miscellaneous	21.87
Reinstatement fee	100.00

\$433.87

Number of Doctors Registered in Manitoba, 1941-50

Year	Outside Winnipeg		Total
	Winnipeg	Winnipeg	
1941	369	200	569
1942	338	197	535
1943	317	178	495
1944	318	179	497
1945	349	177	526
1946	491	223	714
1947	503	226	729
1948	511	236	747
1949	528	233	761
1950	546	229	775

During these same years 589 students graduated from the University of Manitoba and 557 physicians were registered with the College. It will thus be seen that from the third year of World War II, which showed a decline in numbers, a low point was reached during 1943, when practically one-third of the medical population of Canada was engaged in War Service duties. With a peak graduation class of 110 in 1945, the cessation of hostilities, and a record registration of 141 in 1946, there has been continuous improvement until this year the number of registrants resident in the Province is higher than during any previous year.

Schools of Graduation of Doctors Now in Manitoba

University	Winnipeg		Outside Winnipeg		Totals
	Male	Female	Male	Female	
Manitoba	496	34	176	2	620
Other Canadian ..	67	3	26	1	97
United Kingdom ..	28	1	13	1	43
Other	9	---	6	---	15

775

From the above, it will appear that the University of Manitoba graduates number 80% of physicians in the Province of Manitoba at the present time.

Age of Physicians Now in Manitoba

	Winnipeg	Outside Winnipeg	Total
Under 25	6	4	10
25 - 34	133	78	211
35 - 44	146	48	194
45 - 54	111	31	142
55 - 64	77	32	109
65 - 74	53	17	70
75 - 84	22	14	36
85 and over	—	3	3
	<hr/> 548	<hr/> 227	<hr/> 775

The significant factor is that in Winnipeg there are nearly twice as many physicians in the 34 year and under classification than there are in 65 years and over, while outside Winnipeg the figures are more encouraging.

Six members are still with us who graduated and became registered fifty or more years ago:

	Date of Graduation	Date of Registration
William Edward Metcalfe, Portage la Prairie	Man., 1892	June 28, 1892
Jared Norman Andrew, Minnedosa	Man., 1894	May 11, 1895
John Smith Stewart, Newdale	Man., 1894	Sept. 13, 1895
Horatio Clarence Norquay, Selkirk	Man., 1894	Sept. 20, 1895
William Edwin Raymond Coad, Winnipeg	Exam., 1898	April 6, 1900
Francis Daniel McKenty, Winnipeg	Man., 1899	Dec. 7, 1900
While our own John Silas Poole, Neepawa, is a close 7th	Man., 1899	Jan. 17, 1902

We are reminded that there have been losses during the year, the names of deceased members have been read, and include Winnipeg 10, outside Winnipeg 5, other Provinces 13; total 27.

In addition, changes of address or of location, average approximately one daily.

"Are There Enough Doctors?"

Some of you may have seen an editorial which appeared, with above caption, in the Winnipeg Free Press on October 12th, 1950. In an address earlier this month, to the Manitoba Division of the Canadian Medical Association, the Director of Health Insurance Studies, Department of National Health and Welfare, Ottawa, said: "There is also the problem of the shortage of physicians. A careful study of the latest edition of the Survey of Physicians in Canada as at September, 1948, gives a far from encouraging picture. It shows that, although there had been a 2.4% increase in our population during the fifteen-month period under study, there had only been a .7% increase in the total number of physicians. In other words,

our total population is increasing three times fast as our medical personnel." Figures from the Research Division of the same federal department indicate that at September, 1949, there were 13,873 physicians listed, including armed forces personnel, for an estimated population of 13,549,000—a population per physician ratio of 970 which closely approximates the figure of 970 in the United States of America, quoted by Dr. George F. Lull in the editorial. Reasons for increasing medical services are advanced, but in comparing the medical student enrolment with that of 1921, the writer sees little hope for improvement.

On the other side of the ledger, latest figures indicate that the number of graduates of Canadian Medical Schools for:

The 10-year period, 1920-1929	5,150
The 10-year period, 1930-1939	4,177
The 10-year period, 1940-1949	5,922

While the projected figures for 1950-1953 inclusive, are 3,274 or an average annual graduation of 818.5 physicians, figures of actual performance are probably more realistic when related to population than are those of student enrolment.

Chart P. 2 — 1948 Survey of Physicians

Year	Physicians	Population	Population Per Active Physician
1901	5,475	5,323,967	972
1911	7,411	7,191,624	970
1921	8,706	8,775,804	1,008
1931	10,020	10,362,833	1,034
1941	11,873	11,889,713	998
1947	13,263	12,558,000	947
1948	13,355	12,859,000 Y. & N.W.T. excl.	963
1948	13,373	12,883,000 Y. & N.W.T. incl.	963
1949	13,873	13,549,000	977

Are There Enough Doctors for Manitoba?

The Rockefeller Report, 1946, using the basis of 1 physician for every 1,500 population, indicated a shortage of 130 general practitioners and 75 specialists for the area outside Greater Winnipeg after admitting the problem was one of distribution rather than numerical shortage of physicians in the whole province. Population figures used in this survey were those of the 1945 Estimate of Population of Greater Winnipeg—320,000, Balance of Province, 430,000; a total of 750,000. When, however, the actual census figures for 1946 were released early the following year, it was shown that the figures for Greater Winnipeg were 320,480; Balance of Province, 406,439; a total of 726,923; a population less than that of 1941 which was 729,740.

Again when the Report of the Special Selection Committee of the Legislature was released in 1949 the following paragraphs appeared: "What Is Adequate Medical Care?"—The estimated number of practising physicians required to provide an adequate medical service for a population of 750,000 would be 760, according to the Rockefeller Foundation Report on "Personnel Training Requirements under The Health Services Act," using as a basis

calculation the standard set up by the United States Public Health Service, an average of one physician for every 987 persons. (These figures do not include the physicians required in public health work or other governmental services, and full-time administrative medical practices such as hospital administrators and insurance workers).

"Many authorities interested in medical economics, particularly those in the United States, estimate that the ratio should be—one physician to every 750 persons, taking into consideration the expanding medical knowledge and the services which the physicians have to render to the people. If one was to exclude those physicians employed in the various types of full-time service—such as medical personnel employed at hospitals or sanatoria, and in public health or other governmental services, a reasonable ratio of physicians to population would appear to be somewhere in the neighborhood of—one physician (including general and the various specialist types) for every 1,000 people."

Surely the services provided by such physicians are in the nature of health services, and if the deductions are made from the physicians roster, to be consistent, figures should also be deducted from the population to bring the ratio figures into proper perspective, but such has never, to my knowledge, been done. The population of Manitoba residents in the Brandon or Selkirk Hospitals for Mental Diseases are shown in the federal census as residents of Brandon and Selkirk respectively. If physicians were not occupied treating the patients within the walls of the institution, they, or other physicians, would be available to care for the patients in other parts of Manitoba. The same holds true for directors of Health Units, since public health personnel are doing work which was formerly done by general practitioners.

After admitting to an increased number of physicians in the area outside Greater Winnipeg, the ratios of practicing physicians to population were reproduced from the Rockefeller Report, 1946, with inaccurate population figures and similar conclusions were reached.

A Committee of Six was set up to inquire into the shortage of personnel, but any list secured from the Department of Health and Public Welfare contained a maximum of 26 places, some of which were already supplied with physicians, other places which were less desirable.

On March 21st, 1950, the following distribution of medical personnel was reviewed with an officer of the Department of Health and Public Welfare:

	Winnipeg	Rural	Total
Active Practice	375	167	542
Administration	34	8	42
Institutional	74	23	97
Non-Practising	7	2	9

Retired	33	11	44
Temporary	11	5	16
	534	216	750

The number of graduate physicians undergoing postgraduate studies in the province exceeds the number of physicians shown as non-practicing or retired.

It has further been pointed out in respect to the so-called shortage of doctors in rural Manitoba, that if all the residents sought all medical care in their home districts, there would soon be a shift of the medical population away from urban to rural areas. As long as people are free to utilize the local dealer or doctor for the necessary small, emergent services and travel in new cars over good roads to the chain store or city physician for the larger needs (or requirements), there is little encouragement for the dealer or the doctor to remain in the rural area. With all that has been heard of shortages in the rural areas during the past number of years, perhaps 12 openings are available, in only half of which a doctor would make a livelihood.

Manitoba

Year	Physicians	Population	Population Per Active Physician
1911	433	461,394	1,066
1921	557	610,118	1,095
1931	666	700,139	1,051
1941	740	729,744	986
1943	473	680,238	1,438
1946	706	726,923	1,042
1947	759	743,000	979
1948	753	757,000	1,005
1949	735	778,000	1,059
1950	775	795,000	1,025

1951 census figures may be more accurate even as 1946 figures were lower than estimated.

During the attempts to consolidate these figures, many discrepancies appeared in the available reports.

Work on the Medical Register proceeds slowly. Checking data acquired since the deadline continues. 1,535 names are contained by actual count, which suggests that if conditions of employment are sufficiently attractive to recall that number back to Manitoba, including all lost to other provinces, there will be no problem concerning shortages.

Displaced or Refugee Physicians

Every effort has been made to give this matter the sympathetic consideration which it deserves. Your Registrar has endeavoured to meet the persons who have been brought to this country by the Immigration Authorities in the category of miners, foresters, section men, farm or factory labourers,

and who have produced credentials of medical education and for practice, on many occasions, before the contract was completed. No time or effort has been spared to explain regulations with which they are asked to comply, and equivalent only to that required from each and every candidate for registration. In addition, the Registration Committee has invited candidates for a personal interview to attempt a solution of the problem which is not always possible from a mere survey of documents. A period in hospital to acquire a knowledge of the English or French language and up-to-date information concerning medical practice is usually advised.

Respectfully submitted,
M. T. Macfarland, M.D., C.M.,
Registrar.

Motion: "THAT the Registrar be congratulated on his report, and that the report be adopted." Carried.

Motion: "THAT pertinent information from the Registrar's report concerning numbers of physicians, displaced physicians, etc., be abstracted by the Registrar, and be made available to the two daily newspapers." Carried.

Treasurer's and Auditors' Reports

Your Treasurer begs to submit the following report for the year 1949-50. Herewith also submitted auditors' report.

Gordon Bell Memorial Trust Account

There have been no bonds recalled for redemption during the past year and no purchase of bonds. Bonds now held in this account total \$25,000.

There have been no payments made from this account as no scholarship award has been made by the Committee controlling the fund.

Interest accrued on bank balance and from bonds during the year amounts to \$762.34 which with the credit balance on hand a year ago of \$817.48 leaves a present cash balance on hand of \$1,579.82.

Your Treasurer recommends that whenever there is enough bank balance of cash in this account, fully registered Dominion of Canada 3% bonds be purchased for the account of an amount leaving a sufficient working balance in cash.

Investment Trust Account

There have been no bonds recalled for redemption and no purchase of bonds for this account during the past year. Bonds now held amount to \$56,000.

Receipts

Cash on hand October 1, 1949	\$ 961.44
Accrued interest, bonds and bank balance	1,688.90
	<hr/> \$2,650.34

Disbursements, 1949-50

Medical College Library:	
Statutory annual payment	\$ 750.00
Additional grant	400.00
Man. Med Assoc. for Extra Mural expenses	236.19
	<hr/> \$1,436.19

Cash balance on hand October 1, 1950 \$1,214.15

This shows a net gain of cash on hand in the account of \$252.71.

Current Account

Receipts in this account during the past year have been increased chiefly through increased registrations many of which were of Chinese doctors getting out of communist controlled areas in China. Two-thirds of the entire revenue follows from registrations alone. There was also a slight increase due to raising of annual dues to \$5.00.

Expenditure was curtailed by paying the grant of Medical Library and Extra Mural expenses from the Investment Trust fund income account.

Total receipts in current account were	\$12,570.00
Cash disbursements current account were	8,690.00

Total excess of revenue over disbursements	3,880.00
Add cash on hand Oct. 1, 1949	1,688.90
	<hr/> \$ 5,568.90

This is a much more satisfactory statement than that of one year ago when expenditure exceeded income by \$2,275. However, your Treasurer would like to point out to you that this improvement comes chiefly from registrations to practice taken out by transients and that this source of revenue is very uncertain and cannot be depended upon to provide a safe income to meet constantly increasing expenses. Should war occur revenue from registrations will drop to a mere trickle and we should have again to draw from reserves to meet current expense.

Your Treasurer suggests that from the balance on hand, which is non-interest bearing, there be purchased Dominion of Canada fully registered bonds from time to time during the year leaving at all times a sufficient working balance of cash on hand in the current account.

At our May meeting it was debated and proposed that the College donate from its reserve funds a substantial amount for Flood Relief. However, the legality of such disposal of College funds was questioned and, on being referred to our legal advisors, they ruled that according to the Act we could not so dispose of funds. There seems to be a good deal of misunderstanding among the profession in regard to what our funds may be used for.

Dr. The Act says "The Council may expend moneys for encouraging interest in and knowledge of medical and surgical science and practice, and for purposes deemed to be for the general advantage of the medical profession and the members of the college."

Many members of the C.P. & S. would like to see our accumulated reserve funds put to some useful purpose. There is need of an auditorium where medical meetings can be held and also of smaller committee rooms and of office accommodation for the C.P. & S., Manitoba Medical Association, General Practitioners Association, Winnipeg Medical Society, Manitoba Medical Bulletin Office, etc. This seems to your Treasurer to be a real need and to be something "for the general advantage of the medical profession and the members of the college." In the same building there might be a few rooms available for out-of-town members of the College when in Winnipeg. Details could be worked out later.

Auditors' Report

PRICE, WATERHOUSE & CO.

Toronto General Trusts Building,
Winnipeg, October 14, 1950.

The College of Physicians and Surgeons of Manitoba,
Winnipeg, Manitoba.

Dear Sirs:
In accordance with the instructions of your Registrar, we have made an examination of the books and records of The College of Physicians and Surgeons of Manitoba for the year ended September 30, 1950, and for your information we submit the following statements:

Gordon Bell Memorial Fund:

Statement of the Fund— September 30, 1950	Exhibit I
Statement of Changes in the Fund During the Year ended September 30, 1950	Exhibit IA
Statement of Cash Receipts and Disbursements For the Year ended September 30, 1950	Exhibit IB

The Investment Account:

Statement of the Fund— September 30, 1950	Exhibit II
Statement of Changes in the Fund During the Year Ended September 30, 1950	Exhibit IIA
Statement of Cash Receipts and Disbursements For the Year ended September 30, 1950	Exhibit IIB

Current Account:

Summary of Cash Receipts and Disbursements For the Year ended September 30, 1950	Exhibit III
Statement of Cash Receipts For the Year ended September 30, 1950	Exhibit IIIA
Statement of Cash Disbursements For the Year Ended September 30, 1950	Exhibit IIIB

In connection with these statements and our examination of the records we would offer the following comments:

Dominion of Canada Bonds:

We attended at the safety deposit vaults of The Bank of Toronto on October 2, 1950, and, in conjunction with Dr. T. H. Williams and Dr. M. T. Macfarland, examined the Dominion of Canada bonds of a par value of \$25,000.00 as shown under the heading of Gordon Bell Memorial Fund and bonds of a par value of \$56,000.00 as shown under the heading of Investment Account. All of the bonds examined by us were seen to be fully registered in the name of The College of Physicians and Surgeons of Manitoba.

There are coming on the market from time to time in Winnipeg large residential buildings in areas which are no longer first class residential ones. Some of these have been purchased recently for club rooms, college use, etc., at a small fraction of the cost of building at present. The purchase price plus the cost of converting into satisfactory arrangement for our uses should be much less than new construction. Alternatively new construction might be priced or other schemes surveyed. May I suggest the College seriously consider acquiring or building a permanent home embodying such desirable features as may seem fit and necessary and if the suggestion seems worthy that a committee be struck to enquire into costs, plans, maintenance costs, possible revenue, and to fully survey the idea.

Respectfully submitted,

T. H. Williams, M.D., C.M.,
D.T.M. & H., F.C.A.P.,
Treasurer.

Funds on Deposit:

The balances on deposit with The Bank of Toronto at September 30, 1950 in the two savings accounts and the current account have been reconciled with a certificate received by us direct from the bank.

Receipts and Disbursements:

With the exception of the funds on deposit in the current account, which account is non-interest bearing, we have seen that interest has been received on all investments and funds. In the case of the current account we have checked the stubs of receipts issued by the Registrar in connection with registration fees, certificates, annual fees, etc., against the book entries. As a test to ascertain that annual fees received had been properly accounted for we traced the amounts shown in the cash book to the official lists of all members prepared by the College as at September 30, 1950, and at the same time listed any fees which were in arrears as at September 30, 1950: this list of arrears was agreed with a memorandum record maintained by your Registrar.

It will be observed that cash receipts have increased substantially over a year ago. This increase arises chiefly from a greater number of registrations during the current year and the increase of annual fees from \$2.00 to \$5.00 per member which became effective January 1, 1950.

In regard to payments from the Investment Account, we have examined bank advices, minutes and approved vouchers.

With regard to disbursements from the current account we have examined the paid cheques and relative approved vouchers in respect of the items appearing in the books. As the statements submitted relate only to cash receipts and disbursements, we have not gone into the question of any arrears in respect of fees or liabilities outstanding as at September 30, 1950, except to the extent mentioned previously in this report in regard to fees.

The grant to the medical library and the expenses for extra-mural lectures in the amounts of \$1,150.00 and \$286.19 respectively, as shown on Exhibit IIA, were paid from the Investment Account in accordance with Council resolutions whereas, such payments were made from the Current Account in the previous year.

The expenses of council and committee meetings are somewhat greater than a year ago. This increase is attributable chiefly to the increase of fees and travelling allowances for attendance at meetings which were authorized by by-law amendment in May, 1949.

We shall be pleased to furnish you with any additional information you may desire in regard to the attached accounts.

Yours very truly,

Price, Waterhouse & Co.

Exhibit I

**The College of Physicians and Surgeons of Manitoba
Gordon Bell Memorial Fund**

Statement of the Fund, September 30, 1950

INVESTMENTS

Dominion of Canada bonds fully registered in the name of The College of Physicians and Surgeons of Manitoba and carried at par:

3% Victory loan due 1951, 1 bond of \$500.00 numbered K4 Z020847	\$ 500.00
3% Victory loan due 1957, 1 bond of \$1,000.00 numbered L4 M39923	1,000.00
3% Victory loan due 1966, 4 bonds of \$5,000.00 each numbered P7 VI4618-19-20-21, 3 bonds of \$1,000.00 each numbered P7 M56243, M129375-6 and 1 bond of \$500.00 numbered P7 Z73629	23,500.00
	<u>\$25,000.00</u>

Funds on deposit with The Bank of Toronto, per exhibit IB

1,579.82

Amount of the fund, September 30, 1950, per Exhibit IA

\$26,579.82

Exhibit IA

**The College of Physicians and Surgeons of Manitoba
Gordon Bell Memorial Fund**

**Statement of Changes in the Fund
During the Year Ended September 30, 1950**

Amount of the fund, October 1, 1949

\$25,817.48

REVENUE RECEIPTS

Interest on Dominion of Canada bonds ... \$ 750.00
Interest on funds on deposit in The Bank of Toronto

12.34

762.34

Amount of the fund, September 30, 1950, carried to Exhibit I

\$26,579.82

Exhibit IB

**The College of Physicians and Surgeons of Manitoba
Gordon Bell Memorial Fund**

**Statement of Cash Receipts and Disbursements
For the Year Ended September 30, 1950**

Balance of uninvested funds, October 1, 1949

\$ 817.48

CASH RECEIPTS

Interest on Dominion of Canada bonds ... \$ 750.00
Interest on uninvested funds

12.34

762.34

Uninvested funds, September 30, 1950, carried to Exhibit I

\$ 1,579.82

Exhibit II

**The College of Physicians and Surgeons of Manitoba
The Investment Account**

Statement of the Fund, September 30, 1950

INVESTMENTS

Dominion of Canada bonds fully registered in the name of The College of Physicians and Surgeons of Manitoba and carried at par:

3% Victory loan due 1957, 1 bond of \$500.00 numbered L4 Z45631	\$ 500.00
3% Victory loan due 1959, 4 bonds of \$10,000.00 each numbered L7 X04926-7-8-9 and 1 bond of \$5,000.00 numbered L7 V05687	45,000.00

3% Victory loan due 1966, 1 bond of \$5,000.00 numbered P7 V13695, 5 bonds of \$1,000.00 each numbered P7 M103575-6-7, M129373-4 and 1 bond of \$500.00 numbered P7 Z72037	10,500.00
	<u>\$56,000.00</u>

Funds on deposit with The Bank of Toronto, per Exhibit IIB

1.2

Amount of the fund, September 30, 1950, per Exhibit IIA

\$57,2

Exhibit I

**The College of Physicians and Surgeons of Manitoba
The Investment Account**

**Statement of Changes in the Fund
During the Year Ended September 30, 1950**

Amount of the fund, October 1, 1949

\$56,9

REVENUE RECEIPTS:

Interest on Dominion of Canada bonds ... \$ 1,680.00
Interest on funds on deposit in The Bank of Toronto

8.90

1.6

\$59,6

DEDUCT:

Grant to medical library

\$ 1,150.00

Manitoba Medical Association re expenses of extra-mural lectures

286.19

1.4

Amount of the fund, September 30, 1950, carried to Exhibit II

\$57,2

Exhibit I

**The College of Physicians and Surgeons of Manitoba
The Investment Account**

**Statement of Cash Receipts and Disbursements
For the Year Ended September 30, 1950**

Balance of uninvested funds, October 1, 1949

\$ 96

CASH RECEIPTS

Interest on Dominion of Canada bonds ... \$ 1,680.00
Interest on uninvested funds

8.90

1.6

\$2,6

CASH DISBURSEMENTS

Grant to medical library

\$ 1,150.00

Manitoba Medical Association re expenses of extra-mural lectures

286.19

1.4

Uninvested funds, September 30, 1950, carried to Exhibit II

\$ 1.2

Exhibit I

**The College of Physicians and Surgeons of Manitoba
Current Account**

**Summary of Cash Receipts and Disbursements
For the Year Ended September 30, 1950**

Cash in The Bank of Toronto as per books, October 1, 1949

\$ 1.68

Cash receipts, Per Exhibit IIIA

12.57

Cash disbursements, Per Exhibit IIIB

\$14,2

8,6

Cash in The Bank of Toronto as per books, September 30, 1950

\$ 5.56

Reconciliation of Cash in The Bank of Toronto as Shown By Bank Statement with Amount as Shown by the Books

Cash in The Bank of Toronto as per bank statement	\$ 5,965.02
Deduct—Outstanding cheques:	
Dr. C. H. Coffin	\$ 10.22
Dr. C. H. Walton	5.00
Dr. C. E. Corrigan	5.00
Dr. E. Johnson	14.40
Dr. C. B. Stewart	5.00
Dr. J. S. Poole	34.20
Dr. C. H. Walton	5.00
Dr. B. D. Best	5.00
Dr. E. Johnson	14.40
Manitoba Medical Association	200.00
Manitoba Medical Association	90.00
Manitoba Medical Association	4.65
Willson Stationery Co. Ltd.	2.80
	<hr/> 395.67

Cash in The Bank of Toronto as per books, September 30, 1950	\$ 5,569.35
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Exhibit IIIA

The College of Physicians and Surgeons of Manitoba Current Account

Statement of Cash Receipts For the Year Ended September 30, 1950

Registration fees	\$ 8,220.00
Temporary licenses	70.00
Certificates:	
M. C. C.	\$ 435.00
G. M. C.	85.00
	<hr/> 520.00
Annual fees	3,339.00
Reinstatement fee	100.00
Medical students registration fees	78.00
Sales of Mailing lists	227.00
Miscellaneous income	21.87
	<hr/> \$12,575.87

Exhibit IIIB

The College of Physicians and Surgeons of Manitoba Current Account

Statement of Cash Disbursements For the Year Ended September 30, 1950

Salaries:	
Registrar—Dr. M. T. Macfarland	\$ 2,400.00
Treasurer—Dr. T. H. Williams	500.00
	<hr/> \$ 2,900.00

Meetings:

Annual, October, 1949	\$ 628.20
Special, May, 1950	621.80
Executive committee	195.80
Special committees	377.20
	<hr/> 1,823.00

Legal fees	115.00
Amount paid to Manitoba Medical Association in respect of office rental and secretarial services, etc.	2,400.00
Janitor's services—annual and special meetings	14.60
Insurance premiums	43.33
Auditors' fees	125.00
Printing and stationery	353.27
Postage	148.42
Expenses of Registrar re meeting in Halifax	289.50
Miscellaneous office expenses	83.97
Furniture and office equipment	222.33
Exchange on cheques, etc.	4.43
General expenses	35.75
Annual fees refunded	9.00
Registration fees refunded	10.22
Scrutineers' fees	25.00
Manitoba Medical Association re expense of The Workmen's Compensation Board Fee Taxing Committee	90.00

Total disbursements, carried to Exhibit III \$ 8,692.82

Motion: "THAT the Treasurers and Auditors' reports be adopted." Carried.

It was suggested that discussion of these reports should be postponed to the report of the Finance Committee.

4. Reports of Standing Committees and Their Consideration

Executive Committee

Dr. C. B. Stewart stated there had been three meetings of the Executive Committee held during the year, and copies of all minutes had been distributed to each member of Council.

Motion: "THAT the report of the Executive Committee be accepted." Carried.

Social News

Dr. and Mrs. J. D. Colbert (nee Joyce Onhauser), are happy to announce the birth of John Trevor Carlton, Nov. 4, 1950, in Kent, England. Grandpa Dr. Vincent Onhauser proudly struts in Winnipeg.

Dr. and Mrs. Paul Tisdale announce the safe arrival of Mary Ann, Nov. 28, 1950.

Dr. and Mrs. Roy W. Richardson announce the birth of their son, Dec. 29, 1950. They almost held out for that New Year's Baby!

Gathered from a Christmas card that Dr. J. C. Hossack thinks I am a bit of a "stinker" for not

going over to say hello, once in a while. Agreed 100% with the diagnosis. During a telephone chat today he suggested that I incorporate a "Groaners Footnote" in my feeble column. In that way the rest of us have an idea as to who is in the "Out of circulation" list. Of course that means you read this tripe, and also, by the time I get it written the "Groaner" may have stopped one way or the other! It is difficult for me to know who is qualified to help me groan, so please, if you rate, give me a call. At present I can only say to Drs. Hossack, Washington, George, we will all be pleased to see you back on the job. If I don't feel any better tomorrow, boy, will I be groaning! Now I know why kids howl when they have an earache.

your prescription analgesic*

CODOPHEN

C.T. No. 260

E.B.S.



C.T. No. 260
CODOPHEN
 E.B.S.
 Each tablet contains:
 Ebsal, B.B.S. - 3 grs.
 (Acetylsalicylic Acid)
 Phenacetine - 2 grs.
 Caffeine Citrate - 1/4 gr.
 Codeine Phosphate - 1/4 gr.
 Dose: One to three tablets as required

Also supplied as
CODOPHEN STRONGER
 C.T. No. 260A
 containing 1/2 gr. Codeine

NARCOTIC SIGNATURE REQUIRED

** Codophen tablets are orange colored
 but are otherwise unmarked*

THE E.B.S. SHUTTLEWORTH CHEMICAL CO., LTD. TORONTO, CANADA

Representative: Mr. G. A. Roddick, 902 Banning St., Winnipeg

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1950		1949		Total	
	Nov. 5 to Dec. 2, '50	Oct. 8 to Nov. 4, '50	Nov. 6 to Dec. 3, '49	Oct. 9 to Nov. 5, '49	Jan. 1 to Dec. 2, '50	Jan. 1 to Dec. 3, '49
Anterior Poliomyelitis	3	4	2	9	16	118
Chickenpox	242	118	345	219	1446	1537
Diphtheria	0	1	1	0	16	17
Diarrhoea and Enteritis, under 1 yr.	8	12	15	15	126	291
Diphtheria Carriers	0	3	1	0	3	5
Dysentery—Amoebic	0	0	0	0	1	0
Dysentery—Bacillary	2	15	4	5	128	31
Erysipelas	2	1	3	5	47	30
Encephalitis	1	0	1	1	2	37
Influenza	6	13	19	7	157	230
Measles	138	84	465	323	1325	5876
Measles—German	2	2	2	5	35	107
Meningococcal Meningitis	2	1	1	3	14	26
Rumps	132	66	16	17	503	956
Ophthalmia Neonatorum	0	1	0	0	2	1
Pneumonia—Lobar	14	17	21	17	202	197
Quarrel Fever	0	0	0	0	4	5
Scarlet Fever	81	62	102	47	407	251
Septic Sore Throat	2	8	11	8	47	51
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	2	3
Trachoma	0	0	0	4	0	5
Tuberculosis	66	83	73	58	850	1152
Typhoid Fever	1	0	0	1	4	12
Typhoid Paratyphoid	0	0	0	0	0	1
Typhoid Carriers	0	0	0	0	2	4
Undulant Fever	1	2	4	5	28	27
Whooping Cough	79	57	6	7	379	172
Gonorrhoea	94	127	108	129	1217	1399
Syphilis	21	11	28	21	215	378
Malaria	0	0	0	0	5	0

Four-Week Period, November 5th to December 2nd, 1950

DISEASES	*779,000 Manitoba	*3,825,000 Ontario	*861,000 Saskatchewan	*2,952,000 Minnesota
(White Cases Only)				
Approximate population.				
Anterior Poliomyelitis	3	21	7	87
Chickenpox	242	1823	524	---
Diarrhoea and Enteritis, under 1 year	8	---	---	---
Diphtheria	---	---	3	14
Diphtheria Carriers	---	---	6	---
Dysentery—Amoebic	---	---	---	11
Dysentery—Bacillary	2	18	---	8
Encephalitis Epidemica	1	---	1	5
Erysipelas	2	---	1	---
Influenza	6	33	---	1
Measles (infectious)	---	4	6	---
Measles	138	3223	86	56
German Measles	2	196	44	---
Meningitis Meningococcal	2	9	1	5
Rumps	132	1159	330	---
Ophthalmia Neonatorum	---	---	---	---
Pneumonia, Lobar	14	---	---	---
Quarrel Fever	---	---	---	---
Scarlet Fever	81	193	69	51
Septic Sore Throat	2	25	3	18
Smallpox	---	---	---	---
Trichinosis	---	9	---	1
Tuberculosis	66	104	32	242
Typhoid Fever	1	3	1	---
Paratyphoid Fever	---	1	1	1
Typhoid Carrier	---	---	---	---
Undulant Fever	1	4	---	13
Whooping Cough	79	453	8	61
Gonorrhoea	94	240	---	---
Syphilis	21	69	---	---

Just one more four-week period to report before the end of the year and as we look down the column of figures we note that Manitoba has been fortunate in 1950. All figures are low excepting **Bacillary Dysentery**, **Scarlet Fever** and **Whooping Cough** are higher than in 1949 but are still remarkably low.

Poliomyelitis, Diphtheria, Tuberculosis, Typhoid Fever and Syphilis (all important diseases) are lowest they have been for years. The picture in disease prevention is changing and we must put more emphasis on chronic diseases.

DEATHS FROM REPORTABLE DISEASES

For the Month of November, 1950

Urban—Cancer, 43; Diphtheria, 1; Influenza, 1; Pneumonia Lobar (108, 107, 109), 1; Pneumonia (other forms), 6; Tuberculosis, 6; Infectious Hepatitis, 1; Neoplasms of Lymphatic and Haematopoietic Tissues, 7. Other deaths under 1 year, 15. Other deaths over 1 year, 180. Stillbirths, 14. Total, 209.

Rural—Cancer, 34; Influenza, 3; Pneumonia Lobar (108, 107, 109), 1; Pneumonia (other forms), 9; Pneumonia of newborn, 1; Tuberculosis, 6; Whooping Cough, 2; Unspecified Dysentery, 1; Meningococcal Infection, 1; Neoplasms of Lymphatic and Haematopoietic Tissues, 1. Other deaths under 1 year, 11. Other deaths over 1 year, 157. Stillbirths, 10. Total, 178.

Indians — Pneumonia (other forms), 1; Tuberculosis, 3; Whooping Cough, 3; Meningococcal Infection, 1. Other deaths under 1 year, 2. Other deaths over 1 year, 1. Total, 3.

You may prescribe "RAMSES" Vaginal Jelly with full confidence in its safety and effectiveness. No vaginal jelly available provides a greater degree of protection. Supplied in regular (3-oz.) and large (5-oz.) tubes at all recognized pharmacies.

**IMMOBILIZES
IN THE
FASTEST TIME
RECOGNIZED
BY MEDICAL
AUTHORITIES**

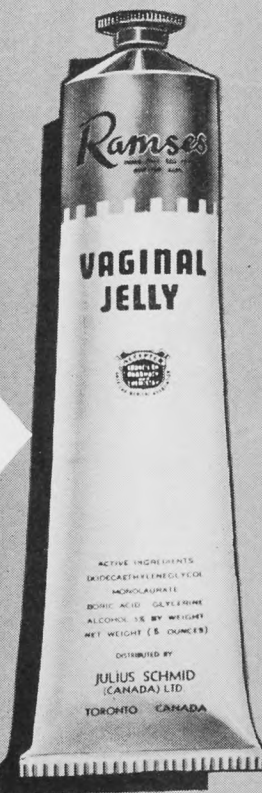


* This immobilization time is measured by the Brown and Gamble technique, the only method accepted by the Council on Pharmacy and Chemistry of the American Medical Association.



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MEDICAL LIBRARY

The University of Manitoba, Faculty of Medicine

Recent Accessions

The Medical Library will prepay all postage charges on Rural Manitoba Loans. There is therefore no charge to the Borrower either when the loans are sent or returned.

General List

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- Aird, Ian. A companion in surgical studies. Livingstone, 1949. 1060 p.
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- Anderson, W. A. D. Pathology. Mosby, 1948. 1453 p.
- Arnold, L. E. and Reitz, H.C. Introduction to organic and biological chemistry. 2nd ed. Mosby, 1949. 795 p.
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Further information concerning the convention may be obtained by writing or telephoning Jerry L. Pettis, Managing Director, Veterans Memorial Hospital, 312 North Boyle Avenue, Los Angeles 33, California. Telephone: ANgels 9-8221, Ext. 280.

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